

PRELIMINARY DRAFT

TEXAS LEGISLATIVE COUNCIL
Government Code
Chapter 540
10/17/22

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6 CHAPTER 540. MEDICAID MANAGED CARE PROGRAM

7 SUBCHAPTER A. GENERAL PROVISIONS

8 Revised Law

9 Sec. 540.0001. DEFINITIONS. In this chapter:

10 (1) Notwithstanding Section _____ [[[Section
11 531.001(2)]]], "commission" means the Health and Human Services
12 Commission or an agency operating part of the Medicaid managed care
13 program, as appropriate.

14 (2) "Health care service region" or "region" means a
15 Medicaid managed care service area the commission delineates.

16 (3) "Managed care organization" means a person that is
17 authorized or otherwise permitted by law to arrange for or provide a
18 managed care plan.

19 (4) "Managed care plan" means a plan under which a
20 person undertakes to provide, arrange for, pay for, or reimburse
21 any part of the cost of any health care service. A part of the plan
22 must consist of arranging for or providing health care services as
23 distinguished from indemnification against the cost of those
24 services on a prepaid basis through insurance or otherwise. The
25 term includes a primary care case management provider network. The
26 term does not include a plan that indemnifies a person for the cost
27 of health care services through insurance.

28 (5) "Potentially preventable event" has the meaning
29 assigned by Section _____ [[[Section 536.001]]].

30 (6) "Recipient" means a Medicaid recipient. (Gov.
31 Code, Secs. 533.001(1), (4), (5), (6), (7), 533.00251(a)(4),
32 533.00253(a)(3), 533.00256(a)(1) (part), 533.00511(a).)

33 Source Law

34 Sec. 533.001. DEFINITIONS. In this chapter:

1 (1) "Commission" means the Health and
2 Human Services Commission or an agency operating part
3 of the state Medicaid managed care program, as
4 appropriate.

5 (4) "Managed care organization" means a
6 person who is authorized or otherwise permitted by law
7 to arrange for or provide a managed care plan.

8 (5) "Managed care plan" means a plan under
9 which a person undertakes to provide, arrange for, pay
10 for, or reimburse any part of the cost of any health
11 care services. A part of the plan must consist of
12 arranging for or providing health care services as
13 distinguished from indemnification against the cost of
14 those services on a prepaid basis through insurance or
15 otherwise. The term includes a primary care case
16 management provider network. The term does not
17 include a plan that indemnifies a person for the cost
18 of health care services through insurance.

19 (6) "Recipient" means a recipient of
20 Medicaid.

21 (7) "Health care service region" or
22 "region" means a Medicaid managed care service area as
23 delineated by the commission.

24 Sec. 533.00251. DELIVERY OF CERTAIN BENEFITS,
25 INCLUDING NURSING FACILITY BENEFITS, THROUGH STAR +
26 PLUS MEDICAID MANAGED CARE PROGRAM. (a) In this
27 section and Sections 533.002515 and 533.00252:

28 (4) "Potentially preventable event" has
29 the meaning assigned by Section 536.001.

30 Sec. 533.00253. STAR KIDS MEDICAID MANAGED CARE
31 PROGRAM. (a) In this section:

32 (3) "Potentially preventable event" has
33 the meaning assigned by Section 536.001.

34 [Sec. 533.00256]

35 (a) . . . [the commission shall:

36 (1) establish a clinical improvement
37 program to . . . reduce] potentially preventable
38 events, as defined by Section 536.001; and

39 . . .

40 Sec. 533.00511. QUALITY-BASED ENROLLMENT
41 INCENTIVE PROGRAM FOR MANAGED CARE ORGANIZATIONS. (a)
42 In this section, "potentially preventable event" has
43 the meaning assigned by Section 536.001.

44 Revisor's Note

45 (1) Section 533.001(1), Government Code,
46 defines "[c]ommission" for purposes of Chapter 533,
47 Government Code, as meaning the Health and Human
48 Services Commission and certain other state agencies.
49 That definition applies to the law revised in this
50 chapter, which is substantially derived from Chapter
51 533. Section 531.001(2), Government Code, which is
52 revised as Section ____ of this subtitle, defines

1 "[c]ommission" for purposes of Subtitle I, Title 4,
2 Government Code, to mean only the Health and Human
3 Services Commission. The law revised in this chapter
4 is derived from Subtitle I, and the definition
5 provided by Section 531.001(2) would apply to this
6 chapter in the absence of the definition provided by
7 Section 533.001(1) that more specifically applies to
8 the law revised in this chapter that is derived from
9 Chapter 533. The provisions of this chapter that are
10 not derived from Chapter 533 do not use the term
11 "commission." The revised law defines "commission" to
12 have the more expansive meaning assigned by Section
13 533.001(1) for purposes of the law revised in this
14 chapter and, for clarity and the convenience of the
15 reader, adds that this definition is
16 "[n]otwithstanding Section _____ [[[Section
17 531.001(2)]]]."

18 (2) Sections 533.001(2) and (3), Government
19 Code, define "[e]xecutive commissioner" and "[h]ealth
20 and human services agencies" for purposes of Chapter
21 533, Government Code. The law revised in this chapter
22 is substantially derived from Chapter 533, and the
23 cited definitions apply to the terms as used in this
24 chapter that are derived from Chapter 533. However,
25 the revised law omits the definitions because the
26 definitions duplicate the definitions for those terms
27 in Section 531.001, Government Code, which is revised
28 in this subtitle as Section _____ and applies to this
29 subtitle, including to the law revised in this
30 chapter. The omitted law reads:

31 (2) "Executive commissioner"
32 means the executive commissioner of the
33 Health and Human Services Commission.

34 (3) "Health and human services
35 agencies" has the meaning assigned by
36 Section 531.001.

1 barriers for recipients in obtaining health care services. (Gov.
2 Code, Sec. 533.002.)

3 Source Law

4 Sec. 533.002. PURPOSE. The commission shall
5 implement the Medicaid managed care program by
6 contracting with managed care organizations in a
7 manner that, to the extent possible:

- 8 (1) improves the health of Texans by:
9 (A) emphasizing prevention;
10 (B) promoting continuity of care; and
11 (C) providing a medical home for
12 recipients;
13 (2) ensures that each recipient receives
14 high quality, comprehensive health care services in
15 the recipient's local community;
16 (3) encourages the training of and access
17 to primary care physicians and providers;
18 (4) maximizes cooperation with existing
19 public health entities, including local departments of
20 health;
21 (5) provides incentives to managed care
22 organizations to improve the quality of health care
23 services for recipients by providing value-added
24 services; and
25 (6) reduces administrative and other
26 nonfinancial barriers for recipients in obtaining
27 health care services.

28 Revised Law

29 Sec. 540.0052. RECIPIENT DIRECTORY. The commission shall,
30 in accordance with a single source of truth design:

31 (1) maintain an accurate electronic directory of
32 contact information for each recipient enrolled in a Medicaid
33 managed care plan offered by a managed care organization,
34 including, to the extent feasible, each recipient's:

- 35 (A) home, work, and mobile telephone numbers;
36 (B) e-mail address; and
37 (C) home and work addresses; and

38 (2) ensure that each Medicaid managed care
39 organization and enrollment broker participating in the Medicaid
40 managed care program update the electronic directory in real time.

41 (Gov. Code, Sec. 533.00751.)

42 Source Law

43 Sec. 533.00751. RECIPIENT DIRECTORY. The
44 commission shall in accordance with a single source of
45 truth design:

46 (1) maintain an accurate electronic
47 directory of contact information for each recipient
48 enrolled in a managed care plan offered by a Medicaid

1 managed care organization under this chapter,
2 including, to the extent feasible, each recipient's:

3 (A) home, work, and mobile telephone
4 numbers;

5 (B) e-mail address; and

6 (C) home and work addresses; and

7 (2) ensure that each Medicaid managed care
8 organization and enrollment broker participating in
9 the Medicaid managed care program update the
10 electronic directory required under Subdivision (1) in
11 real time.

12 Revisor's Note

13 Section 533.00751(1), Government Code, refers to
14 "a managed care plan" offered by a Medicaid managed
15 care organization. Throughout this chapter, the
16 revised law substitutes "Medicaid managed care plan"
17 for "managed care plan" for clarity and consistency
18 when the context is clear that the source law is
19 referring to a managed care plan offered under the
20 Medicaid managed care program.

21 Revised Law

22 Sec. 540.0053. STATEWIDE EFFORT TO PROMOTE MEDICAID
23 ELIGIBILITY MAINTENANCE. (a) The commission shall develop and
24 implement a statewide effort to assist recipients who satisfy
25 Medicaid eligibility requirements and who receive Medicaid
26 services through a Medicaid managed care organization with:

27 (1) maintaining eligibility; and

28 (2) avoiding lapses in Medicaid coverage.

29 (b) As part of the commission's effort under Subsection (a),
30 the commission shall:

31 (1) require each Medicaid managed care organization to
32 assist the organization's recipients with maintaining eligibility;

33 (2) if the commission determines it is cost-effective,
34 develop specific strategies for assisting recipients who receive
35 Supplemental Security Income (SSI) benefits under 42 U.S.C. Section
36 1381 et seq. with maintaining eligibility; and

37 (3) ensure information relevant to a recipient's
38 eligibility status is provided to the recipient's Medicaid managed
39 care organization. (Gov. Code, Sec. 533.0077.)

1 Source Law

2 Sec. 533.0077. STATEWIDE EFFORT TO PROMOTE
3 MAINTENANCE OF ELIGIBILITY. (a) The commission shall
4 develop and implement a statewide effort to assist
5 recipients who satisfy Medicaid eligibility
6 requirements and who receive Medicaid services through
7 a managed care organization with maintaining
8 eligibility and avoiding lapses in coverage under
9 Medicaid.

10 (b) As part of its effort under Subsection (a),
11 the commission shall:

12 (1) require each managed care organization
13 providing health care services to recipients to assist
14 those recipients with maintaining eligibility;

15 (2) if the commission determines it is
16 cost-effective, develop specific strategies for
17 assisting recipients who receive Supplemental
18 Security Income (SSI) benefits under 42 U.S.C. Section
19 1381 et seq. with maintaining eligibility; and

20 (3) ensure information that is relevant to
21 a recipient's eligibility status is provided to the
22 managed care organization through which the recipient
23 receives Medicaid services.

24 Revisor's Note

25 Section 533.0077(a), Government Code, refers to
26 Medicaid recipients who receive "Medicaid services
27 through a managed care organization," and Section
28 533.0077(b)(1), Government Code, refers to a "managed
29 care organization providing health care services to
30 recipients." A managed care organization that
31 provides those services to recipients is a Medicaid
32 managed care organization, which is defined by Section
33 _____ [[[Section 531.001]]] as a managed care
34 organization that contracts with the Health and Human
35 Services Commission under Chapter 533, Government
36 Code, the relevant portions of which are revised in
37 this chapter, to provide health care services to
38 Medicaid recipients. That definition applies
39 subtitle-wide, including to the law revised in this
40 chapter. For consistency of terminology, the revised
41 law substitutes "Medicaid managed care organization"
42 for "managed care organization." Similar changes are
43 made throughout the revised law in this chapter where
44 the context of the law from which the revised law is

1 derived indicates that the reference is specifically
2 to a Medicaid managed care organization rather than to
3 a managed care organization generally.

4 Revised Law

5 Sec. 540.0054. PROVIDER AND RECIPIENT EDUCATION PROGRAMS.

6 (a) In adopting rules to implement a Medicaid managed care program,
7 the executive commissioner shall establish guidelines for, and
8 require Medicaid managed care organizations to provide, education
9 programs for providers and recipients using a variety of techniques
10 and media.

11 (b) A provider education program must include information
12 on:

13 (1) Medicaid policies, procedures, eligibility
14 standards, and benefits;

15 (2) recipients' specific problems and needs; and

16 (3) recipients' rights and responsibilities under the
17 bill of rights and the bill of responsibilities prescribed by
18 Section _____ [[[Section 531.0212]]].

19 (c) A recipient education program must present information
20 in a manner that is easy to understand. A program must include
21 information on:

22 (1) a recipient's rights and responsibilities under
23 the bill of rights and the bill of responsibilities prescribed by
24 Section _____ [[[Section 531.0212]]];

25 (2) how to access health care services;

26 (3) how to access complaint procedures and the
27 recipient's right to bypass the Medicaid managed care
28 organization's internal complaint system and use the notice and
29 appeal procedures otherwise required by Medicaid;

30 (4) Medicaid policies, procedures, eligibility
31 standards, and benefits;

32 (5) the Medicaid managed care organization's policies
33 and procedures; and

34 (6) the importance of prevention, early intervention,

1 and appropriate use of services. (Gov. Code, Sec. 531.0211.)

2 Source Law

3 Sec. 531.0211. MANAGED CARE MEDICAID PROGRAM:
4 RULES; EDUCATION PROGRAMS. (a) In adopting rules to
5 implement a managed care Medicaid program, the
6 executive commissioner shall establish guidelines
7 for, and require managed care organizations to
8 provide, education programs for providers and clients
9 using a variety of techniques and mediums.

10 (b) A provider education program must include
11 information on:

12 (1) Medicaid policies, procedures,
13 eligibility standards, and benefits;

14 (2) the specific problems and needs of
15 Medicaid clients; and

16 (3) the rights and responsibilities of
17 Medicaid clients under the bill of rights and the bill
18 of responsibilities prescribed by Section 531.0212.

19 (c) A client education program must present
20 information in a manner that is easy to understand. A
21 program must include information on:

22 (1) a client's rights and responsibilities
23 under the bill of rights and the bill of
24 responsibilities prescribed by Section 531.0212;

25 (2) how to access health care services;

26 (3) how to access complaint procedures and
27 the client's right to bypass the managed care
28 organization's internal complaint system and use the
29 notice and appeal procedures otherwise required by
30 Medicaid;

31 (4) Medicaid policies, procedures,
32 eligibility standards, and benefits;

33 (5) the policies and procedures of the
34 managed care organization; and

35 (6) the importance of prevention, early
36 intervention, and appropriate use of services.

37 Revisor's Note

38 (1) Section 531.0211(a), Government Code,
39 refers to a "managed care Medicaid program." The
40 revised law substitutes the term "Medicaid managed
41 care program" for "managed care Medicaid program"
42 because the terms are synonymous and "Medicaid managed
43 care program" is more commonly used.

44 (2) Section 531.0211, Government Code, refers
45 to a Medicaid client. The revised law substitutes
46 "recipient" for references to a Medicaid client for
47 clarity and consistency in the terminology used within
48 the chapter and because "recipient," as defined by
49 Section 540.0001 of this chapter, is applicable to the
50 revised law and is more commonly used.

1 Revised Law

2 Sec. 540.0055. MARKETING GUIDELINES. (a) The commission
3 shall establish marketing guidelines for Medicaid managed care
4 organizations, including guidelines that prohibit:

5 (1) door-to-door marketing to a recipient by a
6 Medicaid managed care organization or the organization's agent;

7 (2) using marketing materials with inaccurate or
8 misleading information;

9 (3) making a misrepresentation to a recipient or
10 provider;

11 (4) offering a recipient a material or financial
12 incentive to choose a Medicaid managed care plan, other than a
13 nominal gift or free health screening the commission approves that
14 the Medicaid managed care organization offers to all recipients
15 regardless of whether the recipients enroll in the plan;

16 (5) using a marketing agent who is paid solely by
17 commission; and

18 (6) face-to-face marketing at a public assistance
19 office by a Medicaid managed care organization or the
20 organization's agent.

21 (b) This section does not prohibit:

22 (1) distributing approved marketing materials at a
23 public assistance office; or

24 (2) providing information directly to a recipient
25 under marketing guidelines the commission establishes. (Gov. Code,
26 Secs. 533.008(a), (b).)

27 Source Law

28 Sec. 533.008. MARKETING GUIDELINES. (a) The
29 commission shall establish marketing guidelines for
30 managed care organizations that contract with the
31 commission to provide health care services to
32 recipients, including guidelines that prohibit:

33 (1) door-to-door marketing to recipients
34 by managed care organizations or agents of those
35 organizations;

36 (2) the use of marketing materials with
37 inaccurate or misleading information;

38 (3) misrepresentations to recipients or
39 providers;

40 (4) offering recipients material or

1 financial incentives to choose a managed care plan
2 other than nominal gifts or free health screenings
3 approved by the commission that the managed care
4 organization offers to all recipients regardless of
5 whether the recipients enroll in the managed care
6 plan;

7 (5) the use of marketing agents who are
8 paid solely by commission; and

9 (6) face-to-face marketing at public
10 assistance offices by managed care organizations or
11 agents of those organizations.

12 (b) This section does not prohibit:

13 (1) the distribution of approved marketing
14 materials at public assistance offices; or

15 (2) the provision of information directly
16 to recipients under marketing guidelines established
17 by the commission.

18 Revised Law

19 Sec. 540.0056. GUIDELINES FOR COMMUNICATIONS WITH
20 RECIPIENTS. The executive commissioner shall adopt and publish
21 guidelines for Medicaid managed care organizations regarding how an
22 organization may communicate by text message or e-mail with a
23 recipient enrolled in the organization's Medicaid managed care plan
24 using the contact information provided in the recipient's
25 application for Medicaid benefits under Section 32.025(g)(2),
26 Human Resources Code, including updated information provided to the
27 organization in accordance with Section 32.025(h), Human Resources
28 Code. (Gov. Code, Sec. 533.008(c).)

29 Source Law

30 (c) The executive commissioner shall adopt and
31 publish guidelines for Medicaid managed care
32 organizations regarding how organizations may
33 communicate by text message or e-mail with recipients
34 enrolled in the organization's managed care plan using
35 the contact information provided in a recipient's
36 application for Medicaid benefits under Section
37 32.025(g)(2), Human Resources Code, including updated
38 information provided to the organization in accordance
39 with Section 32.025(h), Human Resources Code.

40 Revised Law

41 Sec. 540.0057. COORDINATION OF EXTERNAL OVERSIGHT
42 ACTIVITIES. (a) To the extent possible, the commission shall
43 coordinate all external oversight activities to minimize
44 duplicating oversight of Medicaid managed care plans and disrupting
45 operations under those plans.

46 (b) The executive commissioner, after consulting with the
47 commission's office of inspector general, shall by rule define the

1 commission's and office's roles in, jurisdiction over, and
2 frequency of audits of Medicaid managed care organizations that are
3 conducted by the commission and the office.

4 (c) In accordance with Sections ____ [[[Sections 531.102(q)
5 and (w)]]], the commission shall share with the commission's office
6 of inspector general, at the office's request, the results of any
7 informal audit or on-site visit that could inform the office's risk
8 assessment when determining:

9 (1) whether to conduct an audit of a Medicaid managed
10 care organization; or

11 (2) the scope of the audit. (Gov. Code, Sec. 533.015.)

12 Source Law

13 Sec. 533.015. COORDINATION OF EXTERNAL
14 OVERSIGHT ACTIVITIES. (a) To the extent possible, the
15 commission shall coordinate all external oversight
16 activities to minimize duplication of oversight of
17 managed care plans under Medicaid and disruption of
18 operations under those plans.

19 (b) The executive commissioner, after
20 consulting with the commission's office of inspector
21 general, shall by rule define the commission's and
22 office's roles in and jurisdiction over, and frequency
23 of, audits of managed care organizations participating
24 in Medicaid that are conducted by the commission and
25 the commission's office of inspector general.

26 (c) [as added Acts 84th Leg., R.S., Ch. 837] In
27 accordance with Section 531.102(q), the commission
28 shall share with the commission's office of inspector
29 general, at the request of the office, the results of
30 any informal audit or onsite visit that could inform
31 that office's risk assessment when determining whether
32 to conduct, or the scope of, an audit of a managed care
33 organization participating in Medicaid.

34 (c) [as added Acts 84th Leg., R.S., Ch. 945] In
35 accordance with Section 531.102(w), the commission
36 shall share with the commission's office of inspector
37 general, at the request of the office, the results of
38 any informal audit or on-site visit that could inform
39 that office's risk assessment when determining whether
40 to conduct, or the scope of, an audit of a managed care
41 organization participating in Medicaid.

42 Revised Law

43 Sec. 540.0058. INFORMATION FOR FRAUD CONTROL. (a) Each
44 Medicaid managed care organization shall submit at no cost to the
45 commission and, on request, the office of the attorney general:

46 (1) a description of any financial or other business
47 relationship between the organization and any subcontractor
48 providing health care services under the contract between the

1 organization and the commission;

2 (2) a copy of each type of contract between the
3 organization and a subcontractor relating to the delivery of or
4 payment for health care services;

5 (3) a description of the fraud control program any
6 subcontractor that delivers health care services uses; and

7 (4) a description and breakdown of all money paid to or
8 by the organization, including a health maintenance organization,
9 primary care case management provider, pharmacy benefit manager,
10 and exclusive provider organization, necessary for the commission
11 to determine the actual cost of administering the Medicaid managed
12 care plan.

13 (b) The information under this section must be:

14 (1) submitted in the form the commission or the office
15 of the attorney general, as applicable, requires; and

16 (2) updated as the commission or the office of the
17 attorney general, as applicable, requires.

18 (c) The commission's office of inspector general or the
19 office of the attorney general, as applicable, shall review the
20 information a Medicaid managed care organization submits under this
21 section as appropriate in investigating fraud in the Medicaid
22 managed care program.

23 (d) Information a Medicaid managed care organization
24 submits to the commission or the office of the attorney general
25 under Subsection (a)(1) is confidential and not subject to
26 disclosure under Chapter 552. (Gov. Code, Sec. 533.012.)

27 Source Law

28 Sec. 533.012. INFORMATION FOR FRAUD CONTROL.

29 (a) Each managed care organization contracting with
30 the commission under this chapter shall submit the
31 following, at no cost, to the commission and, on
32 request, the office of the attorney general:

33 (1) a description of any financial or
34 other business relationship between the organization
35 and any subcontractor providing health care services
36 under the contract;

37 (2) a copy of each type of contract between
38 the organization and a subcontractor relating to the
39 delivery of or payment for health care services;

40 (3) a description of the fraud control

1 program used by any subcontractor that delivers health
2 care services; and

3 (4) a description and breakdown of all
4 funds paid to or by the managed care organization,
5 including a health maintenance organization, primary
6 care case management provider, pharmacy benefit
7 manager, and exclusive provider organization,
8 necessary for the commission to determine the actual
9 cost of administering the managed care plan.

10 (b) The information submitted under this
11 section must be submitted in the form required by the
12 commission or the office of the attorney general, as
13 applicable, and be updated as required by the
14 commission or the office of the attorney general, as
15 applicable.

16 (c) The commission's office of inspector general
17 or the office of the attorney general, as applicable,
18 shall review the information submitted under this
19 section as appropriate in the investigation of fraud
20 in the Medicaid managed care program.

21 (e) Information submitted to the commission or
22 the office of the attorney general, as applicable,
23 under Subsection (a)(1) is confidential and not
24 subject to disclosure under Chapter 552, Government
25 Code.

26 Revisor's Note

27 Section 533.012(a)(4), Government Code, refers
28 to "funds" paid to or by a Medicaid managed care
29 organization. The revised law substitutes "money" for
30 "funds" because, in context, the meaning is the same
31 and "money" is the more commonly used term.

32 Revised Law

33 Sec. 540.0059. MANAGED CARE CLINICAL IMPROVEMENT PROGRAM.

34 (a) In consultation with appropriate stakeholders with an interest
35 in the provision of acute care services and long-term services and
36 supports under the Medicaid managed care program, the commission
37 shall:

38 (1) establish a clinical improvement program to
39 identify goals designed to:

40 (A) improve quality of care and care management;
41 and

42 (B) reduce potentially preventable events; and

43 (2) require Medicaid managed care organizations to
44 develop and implement collaborative program improvement strategies
45 to address the goals.

46 (b) Goals established under this section may be set by

1 geographic region and program type. (Gov. Code, Secs. 533.00256(a)
2 (part), (b).)

3 Source Law

4 Sec. 533.00256. MANAGED CARE CLINICAL
5 IMPROVEMENT PROGRAM. (a) In consultation with
6 appropriate stakeholders with an interest in the
7 provision of acute care services and long-term
8 services and supports under the Medicaid managed care
9 program, the commission shall:

10 (1) establish a clinical improvement
11 program to identify goals designed to improve quality
12 of care and care management and to reduce potentially
13 preventable events . . . ; and

14 (2) require managed care organizations to
15 develop and implement collaborative program
16 improvement strategies to address the goals.

17 (b) Goals established under this section may be
18 set by geographic region and program type.

19 Revised Law

20 Sec. 540.0060. COMPLAINT SYSTEM GUIDELINES. (a) The Texas
21 Department of Insurance, in conjunction with the commission, shall
22 establish complaint system guidelines for Medicaid managed care
23 organizations.

24 (b) The guidelines must require that information regarding
25 a Medicaid managed care organization's complaint process be made
26 available to a recipient in an appropriate communication format
27 when the recipient enrolls in the Medicaid managed care program.

28 (Gov. Code, Secs. 533.020(a) (part), (b).)

29 Source Law

30 Sec. 533.020. MANAGED CARE ORGANIZATIONS:
31 FISCAL SOLVENCY AND COMPLAINT SYSTEM GUIDELINES. (a)
32 The Texas Department of Insurance, in conjunction with
33 the commission, shall establish . . . complaint system
34 guidelines for managed care organizations that serve
35 recipients.

36 (b) The guidelines must require that
37 information regarding a managed care organization's
38 complaint process be made available to a recipient in
39 an appropriate communication format when the recipient
40 enrolls in the Medicaid managed care program.

41 SUBCHAPTER C. FISCAL PROVISIONS

42 Revised Law

43 Sec. 540.0101. FISCAL SOLVENCY STANDARDS. The Texas
44 Department of Insurance, in conjunction with the commission, shall
45 establish fiscal solvency standards for Medicaid managed care
46 organizations. (Gov. Code, Sec. 533.020(a) (part).)

1 to this state as allowable expenses to determine the amount of the
2 experience rebate or profit sharing. (Gov. Code, Sec. 533.0132.)

3 Source Law

4 Sec. 533.0132. STATE TAXES. The commission
5 shall ensure that any experience rebate or profit
6 sharing for managed care organizations is calculated
7 by treating premium, maintenance, and other taxes
8 under the Insurance Code and any other taxes payable to
9 this state as allowable expenses for purposes of
10 determining the amount of the experience rebate or
11 profit sharing.

12 SUBCHAPTER D. STRATEGY FOR MANAGING AUDIT RESOURCES

13 Revised Law

14 Sec. 540.0151. DEFINITIONS. In this subchapter:

15 (1) "Accounts receivable tracking system" means the
16 system the commission uses to track experience rebates and other
17 payments collected from managed care organizations.

18 (2) "Agreed-upon procedures engagement" means an
19 evaluation of a managed care organization's financial statistical
20 reports or other data conducted by an independent auditing firm the
21 commission engages as agreed in the managed care organization's
22 contract with the commission.

23 (3) "Experience rebate" means the amount a managed
24 care organization is required to pay this state according to the
25 graduated rebate method described in the organization's contract
26 with the commission.

27 (4) "External quality review organization" means an
28 organization that performs an external quality review of a managed
29 care organization in accordance with 42 C.F.R. Section 438.350.
30 (Gov. Code, Sec. 533.051.)

31 Source Law

32 Sec. 533.051. DEFINITIONS. In this subchapter:

33 (1) "Accounts receivable tracking system"
34 means the system the commission uses to track
35 experience rebates and other payments collected from
36 managed care organizations.

37 (2) "Agreed-upon procedures engagement"
38 means an evaluation of a managed care organization's
39 financial statistical reports or other data conducted
40 by an independent auditing firm engaged by the
41 commission as agreed in the managed care
42 organization's contract with the commission.

43 (3) "Experience rebate" means the amount a

1 managed care organization is required to pay the state
2 according to the graduated rebate method described in
3 the managed care organization's contract with the
4 commission.

5 (4) "External quality review
6 organization" means an organization that performs an
7 external quality review of a managed care organization
8 in accordance with 42 C.F.R. Section 438.350.

9 Revised Law

10 Sec. 540.0152. APPLICABILITY AND CONSTRUCTION OF
11 SUBCHAPTER. This subchapter does not apply to and may not be
12 construed as affecting the conduct of audits by the commission's
13 office of inspector general under the authority provided by ____
14 [[[Subchapter C, Chapter 531]]], including an audit of a managed
15 care organization the office conducts after coordinating the
16 office's audit and oversight activities with the commission as
17 required by Section ____ [[[Section 531.102(q)]]]. (Gov. Code,
18 Sec. 533.052.)

19 Source Law

20 Sec. 533.052. APPLICABILITY AND CONSTRUCTION OF
21 SUBCHAPTER. This subchapter does not apply to and may
22 not be construed as affecting the conduct of audits by
23 the commission's office of inspector general under the
24 authority provided by Subchapter C, Chapter 531,
25 including an audit of a managed care organization
26 conducted by the office after coordinating the
27 office's audit and oversight activities with the
28 commission as required by Section 531.102(q), as added
29 by Chapter 837 (S.B. 200), Acts of the 84th
30 Legislature, Regular Session, 2015.

31 Revisor's Note

32 Section 533.052, Government Code, refers to
33 Section 531.102(q), Government Code, "as added by
34 Chapter 837 (S.B. 200), Acts of the 84th Legislature,
35 Regular Session, 2015," because another Section
36 531.102(q), Government Code, was added by Chapter 945
37 (S.B. 207), Acts of the 84th Legislature, Regular
38 Session, 2015. The revised law omits the quoted
39 language as unnecessary because Section 531.102(q), as
40 added by Chapter 945 (S.B. 207), was redesignated as
41 Section 531.102(x), Government Code, by Chapter 324
42 (S.B. 1488), Acts of the 85th Legislature, Regular
43 Session, 2017.

1 Revised Law

2 Sec. 540.0153. OVERALL STRATEGY FOR MANAGING AUDIT
3 RESOURCES. The commission shall develop and implement an overall
4 strategy for planning, managing, and coordinating audit resources
5 that the commission uses to verify the accuracy and reliability of
6 program and financial information managed care organizations
7 report. (Gov. Code, Sec. 533.053.)

8 Source Law

9 Sec. 533.053. OVERALL STRATEGY FOR MANAGING
10 AUDIT RESOURCES. The commission shall develop and
11 implement an overall strategy for planning, managing,
12 and coordinating audit resources that the commission
13 uses to verify the accuracy and reliability of program
14 and financial information reported by managed care
15 organizations.

16 Revised Law

17 Sec. 540.0154. PERFORMANCE AUDIT SELECTION PROCESS AND
18 FOLLOW-UP. (a) To improve the commission's processes for
19 performance audits of managed care organizations, the commission
20 shall:

21 (1) document the process by which the commission
22 selects organizations to audit;

23 (2) include previous audit coverage as a risk factor
24 in selecting organizations to audit; and

25 (3) prioritize the highest risk organizations to
26 audit.

27 (b) To verify that managed care organizations correct
28 negative performance audit findings, the commission shall:

29 (1) establish a process to:

30 (A) document how the commission follows up on
31 those findings; and

32 (B) verify that organizations implement
33 performance audit recommendations; and

34 (2) establish and implement policies and procedures
35 to:

36 (A) determine under what circumstances the
37 commission must issue a corrective action plan to an organization

1 based on a performance audit; and

2 (B) follow up on the organization's
3 implementation of the plan. (Gov. Code, Sec. 533.054.)

4 Source Law

5 Sec. 533.054. PERFORMANCE AUDIT SELECTION
6 PROCESS AND FOLLOW-UP. (a) To improve the
7 commission's processes for performance audits of
8 managed care organizations, the commission shall:

9 (1) document the process by which the
10 commission selects managed care organizations to
11 audit;

12 (2) include previous audit coverage as a
13 risk factor in selecting managed care organizations to
14 audit; and

15 (3) prioritize the highest risk managed
16 care organizations to audit.

17 (b) To verify that managed care organizations
18 correct negative performance audit findings, the
19 commission shall:

20 (1) establish a process to:

21 (A) document how the commission
22 follows up on negative performance audit findings; and

23 (B) verify that managed care
24 organizations implement performance audit
25 recommendations; and

26 (2) establish and implement policies and
27 procedures to:

28 (A) determine under what
29 circumstances the commission must issue a corrective
30 action plan to a managed care organization based on a
31 performance audit; and

32 (B) follow up on the managed care
33 organization's implementation of the corrective action
34 plan.

35 Revised Law

36 Sec. 540.0155. AGREED-UPON PROCEDURES ENGAGEMENTS AND
37 CORRECTIVE ACTION PLANS. To enhance the commission's use of
38 agreed-upon procedures engagements to identify managed care
39 organizations' performance and compliance issues, the commission
40 shall:

41 (1) ensure that financial risks identified in
42 agreed-upon procedures engagements are adequately and consistently
43 addressed; and

44 (2) establish policies and procedures to determine
45 under what circumstances the commission must issue a corrective
46 action plan based on an agreed-upon procedures engagement. (Gov.
47 Code, Sec. 533.055.)

1 Source Law

2 Sec. 533.055. AGREED-UPON PROCEDURES
3 ENGAGEMENTS AND CORRECTIVE ACTION PLANS. To enhance
4 the commission's use of agreed-upon procedures
5 engagements to identify managed care organizations'
6 performance and compliance issues, the commission
7 shall:

8 (1) ensure that financial risks identified
9 in agreed-upon procedures engagements are adequately
10 and consistently addressed; and

11 (2) establish policies and procedures to
12 determine under what circumstances the commission must
13 issue a corrective action plan based on an agreed-upon
14 procedures engagement.

15 Revised Law

16 Sec. 540.0156. AUDITS OF PHARMACY BENEFIT MANAGERS. To
17 obtain greater assurance about the effectiveness of pharmacy
18 benefit managers' internal controls and compliance with state
19 requirements, the commission shall:

20 (1) periodically audit each pharmacy benefit manager
21 that contracts with a managed care organization; and

22 (2) develop, document, and implement a monitoring
23 process to ensure that managed care organizations correct and
24 resolve negative findings reported in performance audits or
25 agreed-upon procedures engagements of pharmacy benefit managers.

26 (Gov. Code, Sec. 533.056.)

27 Source Law

28 Sec. 533.056. AUDITS OF PHARMACY BENEFIT
29 MANAGERS. To obtain greater assurance about the
30 effectiveness of pharmacy benefit managers' internal
31 controls and compliance with state requirements, the
32 commission shall:

33 (1) periodically audit each pharmacy
34 benefit manager that contracts with a managed care
35 organization; and

36 (2) develop, document, and implement a
37 monitoring process to ensure that managed care
38 organizations correct and resolve negative findings
39 reported in performance audits or agreed-upon
40 procedures engagements of pharmacy benefit managers.

41 Revised Law

42 Sec. 540.0157. COLLECTING COSTS FOR AUDIT-RELATED
43 SERVICES. The commission shall develop, document, and implement
44 billing processes in the commission's Medicaid and CHIP services
45 department to ensure that managed care organizations reimburse the
46 commission for audit-related services as required by contract.

1 (Gov. Code, Sec. 533.057.)

2 Source Law

3 Sec. 533.057. COLLECTION OF COSTS FOR
4 AUDIT-RELATED SERVICES. The commission shall develop,
5 document, and implement billing processes in the
6 Medicaid and CHIP services department of the
7 commission to ensure that managed care organizations
8 reimburse the commission for audit-related services as
9 required by contract.

10 Revised Law

11 Sec. 540.0158. COLLECTION ACTIVITIES RELATED TO PROFIT
12 SHARING. To strengthen the commission's process for collecting
13 shared profits from managed care organizations, the commission
14 shall develop, document, and implement monitoring processes in the
15 commission's Medicaid and CHIP services department to ensure that
16 the commission:

17 (1) identifies experience rebates deposited in the
18 commission's suspense account and timely transfers those rebates to
19 the appropriate accounts; and

20 (2) timely follows up on and resolves disputes over
21 experience rebates managed care organizations claim. (Gov. Code,
22 Sec. 533.058.)

23 Source Law

24 Sec. 533.058. COLLECTION ACTIVITIES RELATED TO
25 PROFIT SHARING. To strengthen the commission's
26 process for collecting shared profits from managed
27 care organizations, the commission shall develop,
28 document, and implement monitoring processes in the
29 Medicaid and CHIP services department of the
30 commission to ensure that the commission:

31 (1) identifies experience rebates
32 deposited in the commission's suspense account and
33 timely transfers those rebates to the appropriate
34 accounts; and

35 (2) timely follows up on and resolves
36 disputes over experience rebates claimed by managed
37 care organizations.

38 Revised Law

39 Sec. 540.0159. USING INFORMATION FROM EXTERNAL QUALITY
40 REVIEWS. (a) To enhance the commission's monitoring of managed
41 care organizations, the commission shall use the information
42 provided by the external quality review organization, including:

43 (1) detailed data from results of surveys of:

1 (A) recipients and, if applicable, child health
2 plan program enrollees;

3 (B) caregivers of those recipients and
4 enrollees; and

5 (C) Medicaid and, as applicable, child health
6 plan program providers; and

7 (2) the validation results of matching paid claims
8 data with medical records.

9 (b) The commission shall document how the commission uses
10 the information described by Subsection (a) to monitor managed care
11 organizations. (Gov. Code, Sec. 533.059.)

12 Source Law

13 Sec. 533.059. USE OF INFORMATION FROM EXTERNAL
14 QUALITY REVIEWS. (a) To enhance the commission's
15 monitoring of managed care organizations, the
16 commission shall use the information provided by the
17 external quality review organization, including:

18 (1) detailed data from results of surveys
19 of Medicaid recipients and, if applicable, child
20 health plan program enrollees, caregivers of those
21 recipients and enrollees, and Medicaid and, as
22 applicable, child health plan program providers; and

23 (2) the validation results of matching
24 paid claims data with medical records.

25 (b) The commission shall document how the
26 commission uses the information described by
27 Subsection (a) to monitor managed care organizations.

28 Revisor's Note

29 Section 533.059(a)(1), Government Code, refers
30 to "Medicaid recipients." The revised law omits
31 "Medicaid" in that context because the term is
32 included within the definition of "recipient" in
33 Section 533.001, Government Code, revised in this
34 chapter as Section 540.0001.

35 Revised Law

36 Sec. 540.0160. SECURITY OF AND PROCESSING CONTROLS OVER
37 INFORMATION TECHNOLOGY SYSTEMS. The commission shall:

38 (1) strengthen user access controls for the
39 commission's accounts receivable tracking system and network
40 folders that the commission uses to manage the collection of
41 experience rebates;

1 (2) document daily reconciliations of deposits
2 recorded in the accounts receivable tracking system to the
3 transactions processed in:

4 (A) the commission's cost accounting system for
5 all health and human services agencies; and

6 (B) the uniform statewide accounting system; and

7 (3) develop, document, and implement a process to
8 ensure that the commission formally documents:

9 (A) all programming changes made to the accounts
10 receivable tracking system; and

11 (B) the authorization and testing of the changes
12 described by Paragraph (A). (Gov. Code, Sec. 533.060.)

13 Source Law

14 Sec. 533.060. SECURITY AND PROCESSING CONTROLS
15 OVER INFORMATION TECHNOLOGY SYSTEMS. The commission
16 shall:

17 (1) strengthen user access controls for
18 the commission's accounts receivable tracking system
19 and network folders that the commission uses to manage
20 the collection of experience rebates;

21 (2) document daily reconciliations of
22 deposits recorded in the accounts receivable tracking
23 system to the transactions processed in:

24 (A) the commission's cost accounting
25 system for all health and human services agencies; and

26 (B) the uniform statewide accounting
27 system; and

28 (3) develop, document, and implement a
29 process to ensure that the commission formally
30 documents:

31 (A) all programming changes made to
32 the accounts receivable tracking system; and

33 (B) the authorization and testing of
34 the changes described by Paragraph (A).

35 SUBCHAPTER E. CONTRACT ADMINISTRATION

36 Revised Law

37 Sec. 540.0201. CONTRACT ADMINISTRATION IMPROVEMENT
38 EFFORTS. The commission shall make every effort to improve the
39 administration of contracts with managed care organizations. To
40 improve contract administration, the commission shall:

41 (1) ensure that the commission has appropriate
42 expertise and qualified staff to effectively manage contracts with
43 managed care organizations under the Medicaid managed care program;

44 (2) evaluate options for Medicaid payment recovery

1 from a managed care organization if an enrolled recipient:

2 (A) dies;

3 (B) is incarcerated;

4 (C) is enrolled in more than one state program;

5 or

6 (D) is covered by another liable third party
7 insurer;

8 (3) maximize Medicaid payment recovery options by
9 contracting with private vendors to assist in recovering capitation
10 payments, payments from other liable third parties, and other
11 payments made to a managed care organization with respect to an
12 enrolled recipient who leaves the managed care program;

13 (4) decrease the administrative burdens of managed
14 care for this state, managed care organizations, and providers in
15 managed care networks to the extent that those changes are
16 compatible with state law and existing Medicaid managed care
17 contracts, including by:

18 (A) where possible, decreasing duplicate
19 administrative reporting and process requirements for managed care
20 organizations and providers, such as requirements for submitting:

21 (i) encounter data;

22 (ii) quality reports;

23 (iii) historically underutilized business
24 reports; and

25 (iv) claims payment summary reports;

26 (B) allowing a managed care organization to
27 provide updated address information directly to the commission for
28 correction in the state system;

29 (C) promoting consistency and uniformity among
30 managed care organization policies, including policies relating
31 to:

32 (i) the preauthorization process;

33 (ii) lengths of hospital stays;

34 (iii) filing deadlines;

- 1 (iv) levels of care; and
2 (v) case management services;
3 (D) reviewing the appropriateness of primary
4 care case management requirements in the admission and clinical
5 criteria process, such as requirements relating to:
6 (i) including a separate cover sheet for
7 all communications;
8 (ii) submitting handwritten communications
9 instead of electronic or typed review processes; and
10 (iii) admitting patients listed on separate
11 notices; and
12 (E) providing a portal through which a provider
13 in any managed care organization's provider network may submit
14 acute care services and long-term services and supports claims; and
15 (5) reserve the right to amend a managed care
16 organization's process for resolving provider appeals of denials
17 based on medical necessity to include an independent review process
18 the commission establishes for final determination of these
19 disputes. (Gov. Code, Sec. 533.0071.)

20 Source Law

21 Sec. 533.0071. ADMINISTRATION OF CONTRACTS.
22 The commission shall make every effort to improve the
23 administration of contracts with managed care
24 organizations. To improve the administration of
25 these contracts, the commission shall:
26 (1) ensure that the commission has
27 appropriate expertise and qualified staff to
28 effectively manage contracts with managed care
29 organizations under the Medicaid managed care program;
30 (2) evaluate options for Medicaid payment
31 recovery from managed care organizations if the
32 enrollee dies or is incarcerated or if an enrollee is
33 enrolled in more than one state program or is covered
34 by another liable third party insurer;
35 (3) maximize Medicaid payment recovery
36 options by contracting with private vendors to assist
37 in the recovery of capitation payments, payments from
38 other liable third parties, and other payments made to
39 managed care organizations with respect to enrollees
40 who leave the managed care program;
41 (4) decrease the administrative burdens of
42 managed care for the state, the managed care
43 organizations, and the providers under managed care
44 networks to the extent that those changes are
45 compatible with state law and existing Medicaid
46 managed care contracts, including decreasing those
47 burdens by:

1 (A) where possible, decreasing the
2 duplication of administrative reporting and process
3 requirements for the managed care organizations and
4 providers, such as requirements for the submission of
5 encounter data, quality reports, historically
6 underutilized business reports, and claims payment
7 summary reports;

8 (B) allowing managed care
9 organizations to provide updated address information
10 directly to the commission for correction in the state
11 system;

12 (C) promoting consistency and
13 uniformity among managed care organization policies,
14 including policies relating to the preauthorization
15 process, lengths of hospital stays, filing deadlines,
16 levels of care, and case management services;

17 (D) reviewing the appropriateness of
18 primary care case management requirements in the
19 admission and clinical criteria process, such as
20 requirements relating to including a separate cover
21 sheet for all communications, submitting handwritten
22 communications instead of electronic or typed review
23 processes, and admitting patients listed on separate
24 notifications; and

25 (E) providing a portal through which
26 providers in any managed care organization's provider
27 network may submit acute care services and long-term
28 services and supports claims; and

29 (5) reserve the right to amend the managed
30 care organization's process for resolving provider
31 appeals of denials based on medical necessity to
32 include an independent review process established by
33 the commission for final determination of these
34 disputes.

35 Revised Law

36 Sec. 540.0202. PUBLIC NOTICE OF REQUEST FOR CONTRACT
37 APPLICATIONS. Not later than the 30th day before the date the
38 commission plans to issue a request for applications to enter into a
39 contract with the commission to provide health care services to
40 recipients in a region, the commission shall publish notice of and
41 make available for public review the request for applications and
42 all related nonproprietary documents, including the proposed
43 contract. (Gov. Code, Sec. 533.011.)

44 Source Law

45 Sec. 533.011. PUBLIC NOTICE. Not later than the
46 30th day before the commission plans to issue a request
47 for applications to enter into a contract with the
48 commission to provide health care services to
49 recipients in a region, the commission shall publish
50 notice of and make available for public review the
51 request for applications and all related
52 nonproprietary documents, including the proposed
53 contract.

54 Revised Law

55 Sec. 540.0203. CERTIFICATION BY COMMISSION. (a) Before

1 the commission may award a contract under this chapter to a managed
2 care organization, the commission shall evaluate and certify that
3 the organization is reasonably able to fulfill the contract terms,
4 including all federal and state law requirements. Notwithstanding
5 any other law, the commission may not award a contract under this
6 chapter to an organization that does not receive the required
7 certification.

8 (b) A managed care organization may appeal the commission's
9 denial of certification. (Gov. Code, Sec. 533.0035.)

10 Source Law

11 Sec. 533.0035. CERTIFICATION BY COMMISSION.

12 (a) Before the commission may award a contract under
13 this chapter to a managed care organization, the
14 commission shall evaluate and certify that the
15 organization is reasonably able to fulfill the terms
16 of the contract, including all requirements of
17 applicable federal and state law.

18 (b) Notwithstanding any other law, the
19 commission may not award a contract under this chapter
20 to a managed care organization that does not receive
21 the certification required under this section.

22 (c) A managed care organization may appeal a
23 denial of certification by the commission under this
24 section.

25 Revisor's Note

26 Sections 533.0035(a) and (b), Government Code,
27 require the Health and Human Services Commission to
28 evaluate and certify a managed care organization
29 before awarding to the organization a contract under
30 "this chapter," meaning Chapter 533, Government Code.
31 The relevant provisions of Chapter 533 relating to
32 awarding contracts to those organizations are revised
33 in this chapter. The revised law is drafted
34 accordingly.

35 Revised Law

36 Sec. 540.0204. CONTRACT CONSIDERATIONS RELATING TO MANAGED
37 CARE ORGANIZATIONS. In awarding contracts to managed care
38 organizations, the commission shall:

39 (1) give preference to an organization that has
40 significant participation in the organization's provider network

1 from each health care provider in the region who has traditionally
2 provided care to Medicaid and charity care patients;

3 (2) give extra consideration to an organization that
4 agrees to assure continuity of care for at least three months beyond
5 a recipient's Medicaid eligibility period;

6 (3) consider the need to use different managed care
7 plans to meet the needs of different populations; and

8 (4) consider the ability of an organization to process
9 Medicaid claims electronically. (Gov. Code, Sec. 533.003(a)
10 (part).)

11 Source Law

12 Sec. 533.003. CONSIDERATIONS IN AWARDING
13 CONTRACTS. (a) In awarding contracts to managed care
14 organizations, the commission shall:

15 (1) give preference to organizations that
16 have significant participation in the organization's
17 provider network from each health care provider in the
18 region who has traditionally provided care to Medicaid
19 and charity care patients;

20 (2) give extra consideration to
21 organizations that agree to assure continuity of care
22 for at least three months beyond the period of Medicaid
23 eligibility for recipients;

24 (3) consider the need to use different
25 managed care plans to meet the needs of different
26 populations;

27 (4) consider the ability of organizations
28 to process Medicaid claims electronically; and
29 . . .

30 Revisor's Note

31 Section 533.003(a)(5), Government Code, requires
32 the Health and Human Services Commission to give extra
33 consideration to certain managed care organizations
34 when awarding contracts to provide health care
35 services during the commission's initial
36 implementation of managed care in the South Texas
37 service region. According to the commission, the
38 commission has implemented managed care in that
39 region. Accordingly, the revised law omits the
40 provision as executed. The omitted law reads:

41 [Sec. 533.003. CONSIDERATIONS IN
42 AWARDING CONTRACTS. (a) In awarding
43 contracts to managed care organizations,
44 the commission shall:]

1
2 (5) in the initial
3 implementation of managed care in the South
4 Texas service region, give extra
5 consideration to an organization that
6 either:

7 (A) is locally owned,
8 managed, and operated, if one exists; or

9 (B) is in compliance with
10 the requirements of Section 533.004.

11 Revised Law

12 Sec. 540.0205. CONTRACT CONSIDERATIONS RELATING TO
13 PHARMACY BENEFIT MANAGERS. In considering approval of a
14 subcontract between a managed care organization and a pharmacy
15 benefit manager to provide Medicaid prescription drug benefits, the
16 commission shall review and consider whether in the preceding three
17 years the pharmacy benefit manager has been:

18 (1) convicted of:

19 (A) an offense involving a material
20 misrepresentation or an act of fraud; or

21 (B) another violation of state or federal
22 criminal law;

23 (2) adjudicated to have committed a breach of
24 contract; or

25 (3) assessed a penalty or fine of \$500,000 or more in a
26 state or federal administrative proceeding. (Gov. Code, Sec.
27 533.003(b).)

28 Source Law

29 (b) The commission, in considering approval of a
30 subcontract between a managed care organization and a
31 pharmacy benefit manager for the provision of
32 prescription drug benefits under Medicaid, shall
33 review and consider whether the pharmacy benefit
34 manager has been in the preceding three years:

35 (1) convicted of an offense involving a
36 material misrepresentation or an act of fraud or of
37 another violation of state or federal criminal law;

38 (2) adjudicated to have committed a breach
39 of contract; or

40 (3) assessed a penalty or fine in the
41 amount of \$500,000 or more in a state or federal
42 administrative proceeding.

43 Revised Law

44 Sec. 540.0206. MANDATORY CONTRACTS. (a) Subject to the
45 certification required under Section 540.0203 and the

1 considerations required under Section 540.0204, in providing
2 health care services through Medicaid managed care to recipients in
3 a health care service region, the commission shall contract with a
4 managed care organization in that region that holds a certificate
5 of authority issued under Chapter 843, Insurance Code, to provide
6 health care in that region and that is:

7 (1) wholly owned and operated by a hospital district
8 in that region;

9 (2) created by a nonprofit corporation that:

10 (A) has a contract, agreement, or other
11 arrangement with a hospital district in that region or with a
12 municipality in that region that owns a hospital licensed under
13 Chapter 241, Health and Safety Code, and has an obligation to
14 provide health care to indigent patients; and

15 (B) under the contract, agreement, or other
16 arrangement, assumes the obligation to provide health care to
17 indigent patients and leases, manages, or operates a hospital
18 facility the hospital district or municipality owns; or

19 (3) created by a nonprofit corporation that has a
20 contract, agreement, or other arrangement with a hospital district
21 in that region under which the nonprofit corporation acts as an
22 agent of the district and assumes the district's obligation to
23 arrange for services under the Medicaid expansion for children as
24 authorized by Chapter 444 (S.B. 10), Acts of the 74th Legislature,
25 Regular Session, 1995.

26 (b) A managed care organization described by Subsection (a)
27 is subject to all terms to which other managed care organizations
28 are subject, including all contractual, regulatory, and statutory
29 provisions relating to participation in the Medicaid managed care
30 program.

31 (c) The commission shall make the awarding and renewal of a
32 mandatory contract under this section to a managed care
33 organization affiliated with a hospital district or municipality
34 contingent on the district or municipality entering into a matching

1 funds agreement to expand Medicaid for children as authorized by
2 Chapter 444 (S.B. 10), Acts of the 74th Legislature, Regular
3 Session, 1995. The commission shall make compliance with the
4 matching funds agreement a condition of the continuation of the
5 contract with the organization to provide health care services to
6 recipients.

7 (d) In providing health care services through Medicaid
8 managed care to recipients in a health care service region, with the
9 exception of the Harris service area for the STAR Medicaid managed
10 care program, as the commission defined as of September 1, 1999, the
11 commission shall also contract with a managed care organization in
12 that region that holds a certificate of authority as a health
13 maintenance organization issued under Chapter 843, Insurance Code,
14 and that:

15 (1) is certified under Section 162.001, Occupations
16 Code;

17 (2) is created by The University of Texas Medical
18 Branch at Galveston; and

19 (3) has obtained a certificate of authority as a
20 health maintenance organization to serve one or more counties in
21 that region from the Texas Department of Insurance before September
22 2, 1999. (Gov. Code, Secs. 533.004(a), (b), (c), (e).)

23 Source Law

24 Sec. 533.004. MANDATORY CONTRACTS.

25 (a) Subject to the considerations required under
26 Section 533.003 and the certification required under
27 Section 533.0035, in providing health care services
28 through Medicaid managed care to recipients in a
29 health care service region, the commission shall
30 contract with a managed care organization in that
31 region that is licensed under Chapter 843, Insurance
32 Code, to provide health care in that region and that
33 is:

34 (1) wholly owned and operated by a
35 hospital district in that region;

36 (2) created by a nonprofit corporation
37 that:

38 (A) has a contract, agreement, or
39 other arrangement with a hospital district in that
40 region or with a municipality in that region that owns
41 a hospital licensed under Chapter 241, Health and
42 Safety Code, and has an obligation to provide health
43 care to indigent patients; and

44 (B) under the contract, agreement, or

1 other arrangement, assumes the obligation to provide
2 health care to indigent patients and leases, manages,
3 or operates a hospital facility owned by the hospital
4 district or municipality; or

5 (3) created by a nonprofit corporation
6 that has a contract, agreement, or other arrangement
7 with a hospital district in that region under which the
8 nonprofit corporation acts as an agent of the district
9 and assumes the district's obligation to arrange for
10 services under the Medicaid expansion for children as
11 authorized by Chapter 444, Acts of the 74th
12 Legislature, Regular Session, 1995.

13 (b) A managed care organization described by
14 Subsection (a) is subject to all terms and conditions
15 to which other managed care organizations are subject,
16 including all contractual, regulatory, and statutory
17 provisions relating to participation in the Medicaid
18 managed care program.

19 (c) The commission shall make the awarding and
20 renewal of a mandatory contract under this section to a
21 managed care organization affiliated with a hospital
22 district or municipality contingent on the district or
23 municipality entering into a matching funds agreement
24 to expand Medicaid for children as authorized by
25 Chapter 444, Acts of the 74th Legislature, Regular
26 Session, 1995. The commission shall make compliance
27 with the matching funds agreement a condition of the
28 continuation of the contract with the managed care
29 organization to provide health care services to
30 recipients.

31 (e) In providing health care services through
32 Medicaid managed care to recipients in a health care
33 service region, with the exception of the Harris
34 service area for the STAR Medicaid managed care
35 program, as defined by the commission as of September
36 1, 1999, the commission shall also contract with a
37 managed care organization in that region that holds a
38 certificate of authority as a health maintenance
39 organization under Chapter 843, Insurance Code, and
40 that:

41 (1) is certified under Section 162.001,
42 Occupations Code;

43 (2) is created by The University of Texas
44 Medical Branch at Galveston; and

45 (3) has obtained a certificate of
46 authority as a health maintenance organization to
47 serve one or more counties in that region from the
48 Texas Department of Insurance before September 2,
49 1999.

50 Revisor's Note

51 (1) Section 533.004(a), Government Code, refers
52 to the Health and Human Services Commission
53 contracting with a managed care organization,
54 "[s]ubject to the considerations required under
55 Section 533.003," Government Code. Section 533.003 is
56 revised in this chapter as Sections 540.0204 and
57 540.0205. The relevant provisions relating to
58 contract considerations for managed care

1 organizations are revised as Section 540.0204 of this
2 chapter, and the revised law is drafted accordingly.

3 (2) Section 533.004(a), Government Code, refers
4 to a managed care organization that "is licensed"
5 under Chapter 843, Insurance Code. The revised law
6 substitutes "holds a certificate of authority" for the
7 quoted language because Section 843.071, Insurance
8 Code, requires a health maintenance organization to
9 hold a certificate of authority, not a license, to
10 engage in business in this state.

11 (3) Section 533.004(b), Government Code, refers
12 to certain "terms and conditions" to which a managed
13 care organization is subject. The revised law omits
14 "conditions" from the quoted phrase because, in that
15 context, the meaning of "conditions" is included in
16 the meaning of "terms."

17 (4) Section 533.004(d), Government Code,
18 provides that the requirements of Section 533.004(c),
19 Government Code, which is revised in this chapter as
20 Section 540.0206(c), do not apply if the Health and
21 Human Services Commission does not expand Medicaid for
22 children as authorized by Chapter 444 (S.B. 10), Acts
23 of the 74th Legislature, Regular Session, 1995, or a
24 federal waiver for the expansion is not authorized.
25 According to the commission, the commission expanded
26 Medicaid for children as authorized by the Act and
27 obtained a federal waiver. Accordingly, the revised
28 law omits the provision as executed. The omitted law
29 reads:

- 30 (d) Subsection (c) does not apply if:
31 (1) the commission does not
32 expand Medicaid for children as authorized
33 by Chapter 444, Acts of the 74th
34 Legislature, Regular Session, 1995; or
35 (2) a waiver from a federal
36 agency necessary for the expansion is not
37 granted.

1 Revised Law

2 Sec. 540.0207. CONTRACTUAL OBLIGATIONS REVIEW. The
3 commission shall review each Medicaid managed care organization to
4 determine whether the organization is prepared to meet the
5 organization's contractual obligations. (Gov. Code, Sec.
6 533.007(a).)

7 Source Law

8 Sec. 533.007. CONTRACT COMPLIANCE. (a) The
9 commission shall review each managed care organization
10 that contracts with the commission to provide health
11 care services to recipients through a managed care
12 plan issued by the organization to determine whether
13 the organization is prepared to meet its contractual
14 obligations.

15 Revised Law

16 Sec. 540.0208. CONTRACT IMPLEMENTATION PLAN. (a) Each
17 Medicaid managed care organization that contracts to provide health
18 care services to recipients in a health care service region shall
19 submit an implementation plan not later than the 90th day before the
20 date the organization plans to begin providing those services in
21 that region through managed care. The implementation plan must
22 include:

23 (1) specific staffing patterns by function for all
24 operations, including enrollment, information systems, member
25 services, quality improvement, claims management, case management,
26 and provider and recipient training; and

27 (2) specific time frames for demonstrating
28 preparedness for implementation before the date the organization
29 plans to begin providing those services in that region through
30 managed care.

31 (b) The commission shall respond to an implementation plan
32 not later than the 10th day after the date a Medicaid managed care
33 organization submits the plan if the plan does not adequately meet
34 preparedness guidelines.

35 (c) Each Medicaid managed care organization that contracts
36 to provide health care services to recipients in a health care
37 service region shall submit status reports on the implementation

1 plan:

2 (1) not later than the 60th day and the 30th day before
3 the date the organization plans to begin providing those services
4 in that region through managed care; and

5 (2) every 30th day after that date until the 180th day
6 after that date. (Gov. Code, Secs. 533.007(b), (c), (d).)

7 Source Law

8 (b) Each managed care organization that
9 contracts with the commission to provide health care
10 services to recipients in a health care service region
11 shall submit an implementation plan not later than the
12 90th day before the date on which the managed care
13 organization plans to begin to provide health care
14 services to recipients in that region through managed
15 care. The implementation plan must include:

16 (1) specific staffing patterns by function
17 for all operations, including enrollment, information
18 systems, member services, quality improvement, claims
19 management, case management, and provider and
20 recipient training; and

21 (2) specific time frames for demonstrating
22 preparedness for implementation before the date on
23 which the managed care organization plans to begin to
24 provide health care services to recipients in that
25 region through managed care.

26 (c) The commission shall respond to an
27 implementation plan not later than the 10th day after
28 the date a managed care organization submits the plan
29 if the plan does not adequately meet preparedness
30 guidelines.

31 (d) Each managed care organization that
32 contracts with the commission to provide health care
33 services to recipients in a region shall submit status
34 reports on the implementation plan not later than the
35 60th day and the 30th day before the date on which the
36 managed care organization plans to begin to provide
37 health care services to recipients in that region
38 through managed care and every 30th day after that date
39 until the 180th day after that date.

40 Revised Law

41 Sec. 540.0209. COMPLIANCE AND READINESS REVIEW. (a) The
42 commission shall conduct a compliance and readiness review of each
43 Medicaid managed care organization:

44 (1) not later than the 15th day before the date the
45 process of enrolling recipients in a managed care plan the
46 organization issues is to begin in a region; and

47 (2) not later than the 15th day before the date the
48 organization plans to begin providing health care services to
49 recipients in that region through managed care.

1 (b) The compliance and readiness review must include an
2 on-site inspection and tests of service authorization and claims
3 payment systems, including:

4 (1) the Medicaid managed care organization's ability
5 to process claims electronically;

6 (2) the Medicaid managed care organization's complaint
7 processing systems; and

8 (3) any other process or system the contract between
9 the Medicaid managed care organization and the commission requires.

10 (c) The commission may delay recipient enrollment in a
11 managed care plan a Medicaid managed care organization issues if
12 the compliance and readiness review reveals that the organization
13 is not prepared to meet the organization's contractual obligations.
14 The commission shall notify the organization of a decision to delay
15 enrollment in a plan the organization issues. (Gov. Code, Secs.
16 533.007(e), (f).)

17 Source Law

18 (e) The commission shall conduct a compliance
19 and readiness review of each managed care organization
20 that contracts with the commission not later than the
21 15th day before the date on which the process of
22 enrolling recipients in a managed care plan issued by
23 the managed care organization is to begin in a region
24 and again not later than the 15th day before the date
25 on which the managed care organization plans to begin
26 to provide health care services to recipients in that
27 region through managed care. The review must include
28 an on-site inspection and tests of service
29 authorization and claims payment systems, including
30 the ability of the managed care organization to
31 process claims electronically, complaint processing
32 systems, and any other process or system required by
33 the contract.

34 (f) The commission may delay enrollment of
35 recipients in a managed care plan issued by a managed
36 care organization if the review reveals that the
37 managed care organization is not prepared to meet its
38 contractual obligations. The commission shall notify
39 a managed care organization of a decision to delay
40 enrollment in a plan issued by that organization.

41 Revised Law

42 Sec. 540.0210. INTERNET POSTING OF SANCTIONS IMPOSED FOR
43 CONTRACTUAL VIOLATIONS. (a) The commission shall prepare and
44 maintain a record of each enforcement action the commission
45 initiates that results in a sanction, including a penalty, being

1 imposed against a managed care organization for failure to comply
2 with the terms of a contract to provide health care services to
3 recipients through a Medicaid managed care plan the organization
4 issues.

5 (b) The record must include:

- 6 (1) the managed care organization's name and address;
- 7 (2) a description of the contractual obligation the
8 organization failed to meet;
- 9 (3) the date of determination of noncompliance;
- 10 (4) the date the sanction was imposed;
- 11 (5) the maximum sanction that may be imposed under the
12 contract for the violation; and
- 13 (6) the actual sanction imposed against the
14 organization.

15 (c) The commission shall:

- 16 (1) post and maintain on the commission's Internet
17 website the records required by this section:
 - 18 (A) in English and Spanish; and
 - 19 (B) in a format that is readily accessible to and
20 understandable by the public; and
- 21 (2) update the list of records on the website at least
22 quarterly.

23 (d) The commission may not post information under this
24 section that relates to a sanction while the sanction is the subject
25 of an administrative appeal or judicial review.

26 (e) A record prepared under this section may not include
27 information that is excepted from disclosure under Chapter 552.

28 (f) The executive commissioner shall adopt rules as
29 necessary to implement this section. (Gov. Code, Sec. 533.0072.)

30 Source Law

31 Sec. 533.0072. INTERNET POSTING OF SANCTIONS
32 IMPOSED FOR CONTRACTUAL VIOLATIONS. (a) The
33 commission shall prepare and maintain a record of each
34 enforcement action initiated by the commission that
35 results in a sanction, including a penalty, being
36 imposed against a managed care organization for
37 failure to comply with the terms of a contract to

1 provide health care services to recipients through a
2 managed care plan issued by the organization.

3 (b) The record must include:

4 (1) the name and address of the
5 organization;

6 (2) a description of the contractual
7 obligation the organization failed to meet;

8 (3) the date of determination of
9 noncompliance;

10 (4) the date the sanction was imposed;

11 (5) the maximum sanction that may be
12 imposed under the contract for the violation; and

13 (6) the actual sanction imposed against
14 the organization.

15 (c) The commission shall post and maintain the
16 records required by this section on the commission's
17 Internet website in English and Spanish. The records
18 must be posted in a format that is readily accessible
19 to and understandable by a member of the public. The
20 commission shall update the list of records on the
21 website at least quarterly.

22 (d) The commission may not post information
23 under this section that relates to a sanction while the
24 sanction is the subject of an administrative appeal or
25 judicial review.

26 (e) A record prepared under this section may not
27 include information that is excepted from disclosure
28 under Chapter 552.

29 (f) The executive commissioner shall adopt
30 rules as necessary to implement this section.

31 Revised Law

32 Sec. 540.0211. PERFORMANCE MEASURES AND INCENTIVES FOR
33 VALUE-BASED CONTRACTS. (a) The commission shall establish
34 outcome-based performance measures and incentives to include in
35 each contract between the commission and a health maintenance
36 organization to provide health care services to recipients that is
37 procured and managed under a value-based purchasing model. The
38 performance measures and incentives must:

39 (1) be designed to facilitate and increase recipient
40 access to appropriate health care services; and

41 (2) to the extent possible, align with other state and
42 regional quality care improvement initiatives.

43 (b) Subject to Subsection (c), the commission shall include
44 the performance measures and incentives in each contract described
45 by Subsection (a) in addition to all other contract provisions
46 required by this chapter and Chapter _____ [[[Sections 533.00257,
47 533.002571, 533.00258, 533.002581]]].

48 (c) The commission may use a graduated approach to including
49 the performance measures and incentives in contracts described by

1 Subsection (a) to ensure incremental and continued improvements
2 over time.

3 (d) Subject to Subsection (e), the commission shall assess
4 the feasibility and cost-effectiveness of including provisions in a
5 contract described by Subsection (a) that require the health
6 maintenance organization to provide to the providers in the
7 organization's provider network pay-for-performance opportunities
8 that support quality improvements in recipient care.
9 Pay-for-performance opportunities may include incentives for
10 providers to:

- 11 (1) provide care after normal business hours;
- 12 (2) participate in the early and periodic screening,
13 diagnosis, and treatment program; and
- 14 (3) participate in other activities that improve
15 recipient access to care.

16 (e) The commission shall, to the extent possible, base an
17 assessment of feasibility and cost-effectiveness under Subsection
18 (d) on publicly available, scientifically valid, evidence-based
19 criteria appropriate for assessing the Medicaid population.

20 (f) In assessing feasibility and cost-effectiveness under
21 Subsection (d), the commission may consult with participating
22 Medicaid providers, including providers with expertise in quality
23 improvement and performance measurement.

24 (g) If the commission determines that the provisions
25 described by Subsection (d) are feasible and may be cost-effective,
26 the commission shall develop and implement a pilot program in at
27 least one health care service region under which the commission
28 will include the provisions in contracts with health maintenance
29 organizations offering Medicaid managed care plans in the region.

30 (h) The commission shall post the financial statistical
31 report on the commission's Internet website in a comprehensive and
32 understandable format. (Gov. Code, Sec. 533.0051.)

33 Source Law

34 Sec. 533.0051. PERFORMANCE MEASURES AND

1 INCENTIVES FOR VALUE-BASED CONTRACTS. (a) The
2 commission shall establish outcome-based performance
3 measures and incentives to include in each contract
4 between a health maintenance organization and the
5 commission for the provision of health care services
6 to recipients that is procured and managed under a
7 value-based purchasing model. The performance
8 measures and incentives must:

9 (1) be designed to facilitate and increase
10 recipients' access to appropriate health care
11 services; and

12 (2) to the extent possible, align with
13 other state and regional quality care improvement
14 initiatives.

15 (b) Subject to Subsection (c), the commission
16 shall include the performance measures and incentives
17 established under Subsection (a) in each contract
18 described by that subsection in addition to all other
19 contract provisions required by this chapter.

20 (c) The commission may use a graduated approach
21 to including the performance measures and incentives
22 established under Subsection (a) in contracts
23 described by that subsection to ensure incremental and
24 continued improvements over time.

25 (d) Subject to Subsection (f), the commission
26 shall assess the feasibility and cost-effectiveness of
27 including provisions in a contract described by
28 Subsection (a) that require the health maintenance
29 organization to provide to the providers in the
30 organization's provider network pay-for-performance
31 opportunities that support quality improvements in the
32 care of recipients. Pay-for-performance
33 opportunities may include incentives for providers to
34 provide care after normal business hours and to
35 participate in the early and periodic screening,
36 diagnosis, and treatment program and other activities
37 that improve recipients' access to care. If the
38 commission determines that the provisions are feasible
39 and may be cost-effective, the commission shall
40 develop and implement a pilot program in at least one
41 health care service region under which the commission
42 will include the provisions in contracts with health
43 maintenance organizations offering managed care plans
44 in the region.

45 (e) The commission shall post the financial
46 statistical report on the commission's web page in a
47 comprehensive and understandable format.

48 (f) The commission shall, to the extent
49 possible, base an assessment of feasibility and
50 cost-effectiveness under Subsection (d) on publicly
51 available, scientifically valid, evidence-based
52 criteria appropriate for assessing the Medicaid
53 population.

54 (g) In performing the commission's duties under
55 Subsection (d) with respect to assessing feasibility
56 and cost-effectiveness, the commission may consult
57 with participating Medicaid providers, including
58 those with expertise in quality improvement and
59 performance measurement.

60 Revisor's Note

61 Section 533.0051(e), Government Code, refers to
62 the Health and Human Services Commission's "web page."

63 The revised law substitutes the term "Internet

1 website" for "web page" because the terms are
2 synonymous and "Internet website" is more commonly
3 used.

4 Revised Law

5 Sec. 540.0212. MONITORING COMPLIANCE WITH BEHAVIORAL
6 HEALTH INTEGRATION. (a) In this section, "behavioral health
7 services" has the meaning assigned by Section 540.0703.

8 (b) In monitoring contracts the commission enters into with
9 Medicaid managed care organizations under this chapter, the
10 commission shall:

11 (1) ensure the organizations fully integrate
12 behavioral health services into a recipient's primary care
13 coordination;

14 (2) use performance audits and other oversight tools
15 to improve monitoring of the provision and coordination of
16 behavioral health services; and

17 (3) establish performance measures that may be used to
18 determine the effectiveness of the behavioral health services
19 integration.

20 (c) In monitoring a Medicaid managed care organization's
21 compliance with behavioral health services integration
22 requirements under this section, the commission shall give
23 particular attention to an organization that provides behavioral
24 health services through a contract with a third party. (Gov. Code,
25 Sec. 533.002551.)

26 Source Law

27 Sec. 533.002551. MONITORING OF COMPLIANCE WITH
28 BEHAVIORAL HEALTH INTEGRATION. (a) In this section,
29 "behavioral health services" has the meaning assigned
30 by Section 533.00255.

31 (b) In monitoring contracts the commission
32 enters into with managed care organizations under this
33 chapter, the commission shall:

34 (1) ensure managed care organizations
35 fully integrate behavioral health services into a
36 recipient's primary care coordination;

37 (2) use performance audits and other
38 oversight tools to improve monitoring of the provision
39 and coordination of behavioral health services; and

40 (3) establish performance measures that
41 may be used to determine the effectiveness of the

1 integration of behavioral health services.

2 (c) In monitoring a managed care organization's
3 compliance with behavioral health services
4 integration requirements under this section, the
5 commission shall give particular attention to a
6 managed care organization that provides behavioral
7 health services through a contract with a third party.

8 SUBCHAPTER F. REQUIRED CONTRACT PROVISIONS

9 Revised Law

10 Sec. 540.0251. APPLICABILITY. This subchapter applies to a
11 contract between a Medicaid managed care organization and the
12 commission to provide health care services to recipients. (Gov.
13 Code, Sec. 533.005(a) (part).)

14 Source Law

15 Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
16 (a) A contract between a managed care organization and
17 the commission for the organization to provide health
18 care services to recipients must contain:

19 . . .

20 Revised Law

21 Sec. 540.0252. ACCOUNTABILITY TO STATE. A contract to
22 which this subchapter applies must contain procedures to ensure
23 accountability to this state for providing health care services,
24 including procedures for:

- 25 (1) financial reporting;
26 (2) quality assurance;
27 (3) utilization review; and
28 (4) assurance of contract and subcontract compliance.

29 (Gov. Code, Sec. 533.005(a)(1).)

30 Source Law

31 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
32 (a) A contract between a managed care organization and
33 the commission for the organization to provide health
34 care services to recipients must contain:]

35 (1) procedures to ensure accountability to
36 the state for the provision of health care services,
37 including procedures for financial reporting, quality
38 assurance, utilization review, and assurance of
39 contract and subcontract compliance;

40 . . .

41 Revised Law

42 Sec. 540.0253. CAPITATION RATES. A contract to which this
43 subchapter applies must contain capitation rates that:

- 44 (1) include acuity and risk adjustment methodologies

1 that consider the costs of providing acute care services and
2 long-term services and supports, including private duty nursing
3 services, provided under the Medicaid managed care plan; and

4 (2) ensure the cost-effective provision of quality
5 health care. (Gov. Code, Sec. 533.005(a)(2).)

6 Source Law

7 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
8 (a) A contract between a managed care organization and
9 the commission for the organization to provide health
10 care services to recipients must contain:]

- 11 . . .
12 (2) capitation rates that:
13 (A) include acuity and risk
14 adjustment methodologies that consider the costs of
15 providing acute care services and long-term services
16 and supports, including private duty nursing services,
17 provided under the plan; and
18 (B) ensure the cost-effective
19 provision of quality health care;
20 . . .

21 Revisor's Note

22 Section 533.005(a)(2)(A), Government Code,
23 refers to capitation rates for services and supports
24 provided under a Medicaid managed care organization's
25 "plan." Because an organization that contracts with
26 the Health and Human Services Commission under Chapter
27 533, Government Code, to provide health care services
28 to Medicaid recipients provides those services through
29 a Medicaid managed care plan, and because it is clear
30 from the context that is the plan to which the source
31 law refers, the revised law substitutes "Medicaid
32 managed care plan" for "plan" for the convenience of
33 the reader.

34 Revised Law

35 Sec. 540.0254. COST INFORMATION. A contract to which this
36 subchapter applies must require the contracting Medicaid managed
37 care organization and any entity with which the organization
38 contracts to perform services under a Medicaid managed care plan to
39 disclose at no cost to the commission and, on request, the office of
40 the attorney general all agreements affecting the net cost of goods

1 or services provided under the plan, including:

- 2 (1) discounts;
- 3 (2) incentives;
- 4 (3) rebates;
- 5 (4) fees;
- 6 (5) free goods; and
- 7 (6) bundling arrangements. (Gov. Code, Sec.
- 8 533.005(a)(24).)

9 Source Law

10 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
11 (a) A contract between a managed care organization
12 and the commission for the organization to provide
13 health care services to recipients must contain:]

14 . . .
15 (24) a requirement that the managed care
16 organization and any entity with which the managed
17 care organization contracts for the performance of
18 services under a managed care plan disclose, at no
19 cost, to the commission and, on request, the office of
20 the attorney general all discounts, incentives,
21 rebates, fees, free goods, bundling arrangements, and
22 other agreements affecting the net cost of goods or
23 services provided under the plan;

24 . . .

25 Revised Law

26 Sec. 540.0255. FRAUD CONTROL. A contract to which this
27 subchapter applies must require the contracting Medicaid managed
28 care organization to:

- 29 (1) provide the information required by Section
- 30 540.0058; and
- 31 (2) otherwise comply and cooperate with the
- 32 commission's office of inspector general and the office of the
- 33 attorney general. (Gov. Code, Sec. 533.005(a)(10).)

34 Source Law

35 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
36 (a) A contract between a managed care organization
37 and the commission for the organization to provide
38 health care services to recipients must contain:]

39 . . .
40 (10) a requirement that the managed care
41 organization provide the information required by
42 Section 533.012 and otherwise comply and cooperate
43 with the commission's office of inspector general and
44 the office of the attorney general;

45 . . .

1 Revised Law

2 Sec. 540.0256. RECIPIENT OUTREACH AND EDUCATION. A
3 contract to which this subchapter applies must:

4 (1) require the contracting Medicaid managed care
5 organization to provide:

6 (A) information about the availability of and
7 referral to educational, social, and other community services that
8 could benefit a recipient; and

9 (B) special programs and materials for
10 recipients with limited English proficiency or low literacy skills;
11 and

12 (2) contain procedures for recipient outreach and
13 education. (Gov. Code, Secs. 533.005(a)(5), (6), (18).)

14 Source Law

15 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
16 (a) A contract between a managed care organization
17 and the commission for the organization to provide
18 health care services to recipients must contain:]

19 . . .
20 (5) a requirement that the managed care
21 organization provide information and referral about
22 the availability of educational, social, and other
23 community services that could benefit a recipient;

24 (6) procedures for recipient outreach and
25 education;

26 . . .
27 (18) a requirement that the managed care
28 organization provide special programs and materials
29 for recipients with limited English proficiency or low
30 literacy skills;

31 . . .

32 Revised Law

33 Sec. 540.0257. NOTICE OF MEDICAID CERTIFICATION DATE. A
34 contract to which this subchapter applies must require the
35 commission to inform the contracting Medicaid managed care
36 organization, on the date of a recipient's enrollment in a Medicaid
37 managed care plan the organization issues, of the recipient's
38 Medicaid certification date. (Gov. Code, Sec. 533.005(a)(8).)

39 Source Law

40 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
41 (a) A contract between a managed care organization
42 and the commission for the organization to provide
43 health care services to recipients must contain:]

44 . . .

1 (8) a requirement that the commission, on
2 the date of a recipient's enrollment in a managed care
3 plan issued by the managed care organization, inform
4 the organization of the recipient's Medicaid
5 certification date;

6 . . .

7 Revised Law

8 Sec. 540.0258. PRIMARY CARE PROVIDER ASSIGNMENT. A
9 contract to which this subchapter applies must require the
10 contracting Medicaid managed care organization to make initial and
11 subsequent primary care provider assignments and changes. (Gov.
12 Code, Sec. 533.005(a)(26).)

13 Source Law

14 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
15 (a) A contract between a managed care organization
16 and the commission for the organization to provide
17 health care services to recipients must contain:]

18 . . .

19 (26) a requirement that the managed care
20 organization make initial and subsequent primary care
21 provider assignments and changes.

22 Revised Law

23 Sec. 540.0259. COMPLIANCE WITH PROVIDER NETWORK
24 REQUIREMENTS. A contract to which this subchapter applies must
25 require the contracting Medicaid managed care organization to
26 comply with Sections 540.0651(a)(1) and (2) and (b) as a condition
27 of contract retention and renewal. (Gov. Code, Sec. 533.005(a)(9).)

28 Source Law

29 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
30 (a) A contract between a managed care organization
31 and the commission for the organization to provide
32 health care services to recipients must contain:]

33 . . .

34 (9) a requirement that the managed care
35 organization comply with Section 533.006 as a
36 condition of contract retention and renewal;

37 . . .

38 Revised Law

39 Sec. 540.0260. COMPLIANCE WITH PROVIDER ACCESS STANDARDS;
40 REPORT. A contract to which this subchapter applies must require
41 the contracting Medicaid managed care organization to:

42 (1) develop and submit to the commission, before the
43 organization begins providing health care services to recipients, a
44 comprehensive plan that describes how the organization's provider

1 network complies with the provider access standards the commission
2 establishes under Section 540.0652;

3 (2) as a condition of contract retention and renewal:

4 (A) continue to comply with the provider access
5 standards; and

6 (B) make substantial efforts, as the commission
7 determines, to mitigate or remedy any noncompliance with the
8 provider access standards;

9 (3) pay liquidated damages for each failure, as the
10 commission determines, to comply with the provider access standards
11 in amounts that are reasonably related to the noncompliance; and

12 (4) regularly, as the commission determines, submit to
13 the commission and make available to the public a report
14 containing:

15 (A) data on the organization's provider network
16 sufficiency with regard to providing the care and services
17 described by Section 540.0652(a); and

18 (B) specific data with respect to access to
19 primary care, specialty care, long-term services and supports,
20 nursing services, and therapy services on the average length of
21 time between:

22 (i) the date a provider requests prior
23 authorization for the care or service and the date the organization
24 approves or denies the request; and

25 (ii) the date the organization approves a
26 request for prior authorization for the care or service and the date
27 the care or service is initiated. (Gov. Code, Sec. 533.005(a)(20).)

28 Source Law

29 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
30 (a) A contract between a managed care organization
31 and the commission for the organization to provide
32 health care services to recipients must contain:]

33 . . .
34 (20) a requirement that the managed care
35 organization:

36 (A) develop and submit to the
37 commission, before the organization begins to provide
38 health care services to recipients, a comprehensive
39 plan that describes how the organization's provider

1 network complies with the provider access standards
2 established under Section 533.0061;

3 (B) as a condition of contract
4 retention and renewal:

5 (i) continue to comply with the
6 provider access standards established under Section
7 533.0061; and

8 (ii) make substantial efforts,
9 as determined by the commission, to mitigate or remedy
10 any noncompliance with the provider access standards
11 established under Section 533.0061;

12 (C) pay liquidated damages for each
13 failure, as determined by the commission, to comply
14 with the provider access standards established under
15 Section 533.0061 in amounts that are reasonably
16 related to the noncompliance; and

17 (D) regularly, as determined by the
18 commission, submit to the commission and make
19 available to the public a report containing data on the
20 sufficiency of the organization's provider network
21 with regard to providing the care and services
22 described under Section 533.0061(a) and specific data
23 with respect to access to primary care, specialty
24 care, long-term services and supports, nursing
25 services, and therapy services on the average length
26 of time between:

27 (i) the date a provider
28 requests prior authorization for the care or service
29 and the date the organization approves or denies the
30 request; and

31 (ii) the date the organization
32 approves a request for prior authorization for the
33 care or service and the date the care or service is
34 initiated;

35 . . .

36 Revised Law

37 Sec. 540.0261. PROVIDER NETWORK SUFFICIENCY. A contract to
38 which this subchapter applies must require the contracting Medicaid
39 managed care organization to demonstrate to the commission, before
40 the organization begins providing health care services to
41 recipients, that, subject to the provider access standards the
42 commission establishes under Section 540.0652:

43 (1) the organization's provider network has the
44 capacity to serve the number of recipients expected to enroll in a
45 Medicaid managed care plan the organization offers;

46 (2) the organization's provider network includes:

47 (A) a sufficient number of primary care
48 providers;

49 (B) a sufficient variety of provider types;

50 (C) a sufficient number of long-term services and
51 supports providers and specialty pediatric care providers of home

1 and community-based services; and

2 (D) providers located throughout the region in
3 which the organization will provide health care services; and

4 (3) health care services will be accessible to
5 recipients through the organization's provider network to a
6 comparable extent that health care services would be available to
7 recipients under a fee-for-service model or primary care case
8 management Medicaid managed care model. (Gov. Code, Sec.
9 533.005(a)(21).)

10 Source Law

11 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
12 (a) A contract between a managed care organization
13 and the commission for the organization to provide
14 health care services to recipients must contain:]

15 . . .
16 (21) a requirement that the managed care
17 organization demonstrate to the commission, before the
18 organization begins to provide health care services to
19 recipients, that, subject to the provider access
20 standards established under Section 533.0061:

21 (A) the organization's provider
22 network has the capacity to serve the number of
23 recipients expected to enroll in a managed care plan
24 offered by the organization;

25 (B) the organization's provider
26 network includes:

27 (i) a sufficient number of
28 primary care providers;

29 (ii) a sufficient variety of
30 provider types;

31 (iii) a sufficient number of
32 providers of long-term services and supports and
33 specialty pediatric care providers of home and
34 community-based services; and

35 (iv) providers located
36 throughout the region where the organization will
37 provide health care services; and

38 (C) health care services will be
39 accessible to recipients through the organization's
40 provider network to a comparable extent that health
41 care services would be available to recipients under a
42 fee-for-service or primary care case management model
43 of Medicaid managed care;

44 . . .

45 Revised Law

46 Sec. 540.0262. QUALITY MONITORING PROGRAM FOR HEALTH CARE
47 SERVICES. A contract to which this subchapter applies must require
48 the contracting Medicaid managed care organization to develop a
49 monitoring program for measuring the quality of the health care
50 services provided by the organization's provider network that:

1 (1) incorporates the National Committee for Quality
2 Assurance's Healthcare Effectiveness Data and Information Set
3 (HEDIS) measures or, as applicable, the national core indicators
4 adult consumer survey and the national core indicators child family
5 survey for individuals with an intellectual or developmental
6 disability;

7 (2) focuses on measuring outcomes; and

8 (3) includes collecting and analyzing clinical data
9 relating to prenatal care, preventive care, mental health care, and
10 the treatment of acute and chronic health conditions and substance
11 use. (Gov. Code, Sec. 533.005(a)(22).)

12 Source Law

13 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
14 (a) A contract between a managed care organization
15 and the commission for the organization to provide
16 health care services to recipients must contain:]

17 . . .
18 (22) a requirement that the managed care
19 organization develop a monitoring program for
20 measuring the quality of the health care services
21 provided by the organization's provider network that:

22 (A) incorporates the National
23 Committee for Quality Assurance's Healthcare
24 Effectiveness Data and Information Set (HEDIS)
25 measures or, as applicable, the national core
26 indicators adult consumer survey and the national core
27 indicators child family survey for individuals with an
28 intellectual or developmental disability;

29 (B) focuses on measuring outcomes;
30 and

31 (C) includes the collection and
32 analysis of clinical data relating to prenatal care,
33 preventive care, mental health care, and the treatment
34 of acute and chronic health conditions and substance
35 abuse;

36 . . .

37 Revisor's Note

38 Section 533.005(a)(22)(C), Government Code,
39 refers to the treatment of "substance abuse." The
40 Diagnostic and Statistical Manual of Mental Disorders,
41 5th Edition (DSM-5), published by the American
42 Psychiatric Association to assist in classifying
43 mental disorders, combines the categories of substance
44 abuse and substance dependence into a single disorder
45 referred to as "substance use disorder." Therefore,

1 the revised law substitutes "substance use" for
2 "substance abuse" to reflect modern terminology
3 regarding the disorder.

4 Revised Law

5 Sec. 540.0263. OUT-OF-NETWORK PROVIDER USAGE AND
6 REIMBURSEMENT. (a) A contract to which this subchapter applies
7 must require that:

8 (1) the contracting Medicaid managed care
9 organization's usages of out-of-network providers or groups of
10 out-of-network providers may not exceed limits the commission
11 determines for those usages relating to total inpatient admissions,
12 total outpatient services, and emergency room admissions; and

13 (2) the organization reimburse an out-of-network
14 provider for health care services at a rate that is equal to the
15 allowable rate for those services as determined under Sections
16 32.028 and 32.0281, Human Resources Code, if the commission finds
17 that the organization violated Subdivision (1).

18 (b) In accordance with Subsection (a)(2), a Medicaid
19 managed care organization must reimburse an out-of-network
20 provider of poststabilization services for providing the services
21 at the allowable rate for those services until the organization
22 arranges for the recipient's timely transfer, as the recipient's
23 attending physician determines, to a provider in the organization's
24 provider network. The organization may not refuse to reimburse an
25 out-of-network provider for emergency or poststabilization
26 services provided as a result of the organization's failure to
27 arrange for and authorize a recipient's timely transfer. (Gov.
28 Code, Secs. 533.005(a)(11), (12), (b).)

29 Source Law

30 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
31 (a) A contract between a managed care organization
32 and the commission for the organization to provide
33 health care services to recipients must contain:]

34 . . .
35 (11) a requirement that the managed care
36 organization's usages of out-of-network providers or
37 groups of out-of-network providers may not exceed
38 limits for those usages relating to total inpatient

1 admissions, total outpatient services, and emergency
2 room admissions determined by the commission;

3 (12) if the commission finds that a
4 managed care organization has violated Subdivision
5 (11), a requirement that the managed care organization
6 reimburse an out-of-network provider for health care
7 services at a rate that is equal to the allowable rate
8 for those services, as determined under Sections
9 32.028 and 32.0281, Human Resources Code;

10 . . .

11 (b) In accordance with Subsection (a)(12), all
12 post-stabilization services provided by an
13 out-of-network provider must be reimbursed by the
14 managed care organization at the allowable rate for
15 those services until the managed care organization
16 arranges for the timely transfer of the recipient, as
17 determined by the recipient's attending physician, to
18 a provider in the network. A managed care organization
19 may not refuse to reimburse an out-of-network provider
20 for emergency or post-stabilization services provided
21 as a result of the managed care organization's failure
22 to arrange for and authorize a timely transfer of a
23 recipient.

24 Revised Law

25 Sec. 540.0264. PROVIDER REIMBURSEMENT RATE REDUCTION. (a)
26 A contract to which this subchapter applies must require that the
27 contracting Medicaid managed care organization not implement a
28 significant, nonnegotiated, across-the-board provider
29 reimbursement rate reduction unless:

30 (1) subject to Subsection (b), the organization has
31 the commission's prior approval to implement the reduction; or

32 (2) the rate reduction is based on changes to the
33 Medicaid fee schedule or cost containment initiatives the
34 commission implements.

35 (b) A provider reimbursement rate reduction a Medicaid
36 managed care organization proposes is considered to have received
37 the commission's prior approval unless the commission issues a
38 written statement of disapproval not later than the 45th day after
39 the date the commission receives notice of the proposed rate
40 reduction from the organization. (Gov. Code, Secs. 533.005(a)(25),
41 (a-3).)

42 Source Law

43 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
44 (a) A contract between a managed care organization and
45 the commission for the organization to provide health
46 care services to recipients must contain:]

47 . . .

1 (25) a requirement that the managed care
2 organization not implement significant,
3 nonnegotiated, across-the-board provider
4 reimbursement rate reductions unless:

5 (A) subject to Subsection (a-3), the
6 organization has the prior approval of the commission
7 to make the reductions; or

8 (B) the rate reductions are based on
9 changes to the Medicaid fee schedule or cost
10 containment initiatives implemented by the
11 commission; and
12 . . .

13 (a-3) For purposes of Subsection (a)(25)(A), a
14 provider reimbursement rate reduction is considered to
15 have received the commission's prior approval unless
16 the commission issues a written statement of
17 disapproval not later than the 45th day after the date
18 the commission receives notice of the proposed rate
19 reduction from the managed care organization.

20 Revised Law

21 Sec. 540.0265. PROMPT PAYMENT OF CLAIMS. (a) A contract to
22 which this subchapter applies must require the contracting Medicaid
23 managed care organization to pay a physician or provider for health
24 care services provided to a recipient under a Medicaid managed care
25 plan on any claim for payment the organization receives with
26 documentation reasonably necessary for the organization to process
27 the claim:

28 (1) not later than:

29 (A) the 10th day after the date the organization
30 receives the claim if the claim relates to services a nursing
31 facility, intermediate care facility, or group home provided;

32 (B) the 30th day after the date the organization
33 receives the claim if the claim relates to the provision of
34 long-term services and supports not subject to Paragraph (A); and

35 (C) the 45th day after the date the organization
36 receives the claim if the claim is not subject to Paragraph (A) or
37 (B); or

38 (2) within a period, not to exceed 60 days, specified
39 by a written agreement between the physician or provider and the
40 organization.

41 (b) A contract to which this subchapter applies must require
42 the contracting Medicaid managed care organization to demonstrate
43 to the commission that the organization pays claims described by

1 Subsection (a)(1)(B) on average not later than the 21st day after
2 the date the organization receives the claim. (Gov. Code, Secs.
3 533.005(a)(7), (7-a).)

4 Source Law

5 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
6 (a) A contract between a managed care organization
7 and the commission for the organization to provide
8 health care services to recipients must contain:]

9 . . .
10 (7) a requirement that the managed care
11 organization make payment to a physician or provider
12 for health care services rendered to a recipient under
13 a managed care plan on any claim for payment that is
14 received with documentation reasonably necessary for
15 the managed care organization to process the claim:

16 (A) not later than:

17 (i) the 10th day after the date
18 the claim is received if the claim relates to services
19 provided by a nursing facility, intermediate care
20 facility, or group home;

21 (ii) the 30th day after the date
22 the claim is received if the claim relates to the
23 provision of long-term services and supports not
24 subject to Subparagraph (i); and

25 (iii) the 45th day after the
26 date the claim is received if the claim is not subject
27 to Subparagraph (i) or (ii); or

28 (B) within a period, not to exceed 60
29 days, specified by a written agreement between the
30 physician or provider and the managed care
31 organization;

32 (7-a) a requirement that the managed care
33 organization demonstrate to the commission that the
34 organization pays claims described by Subdivision
35 (7)(A)(ii) on average not later than the 21st day after
36 the date the claim is received by the organization;
37 . . .

38 Revised Law

39 Sec. 540.0266. REIMBURSEMENT FOR CERTAIN SERVICES PROVIDED
40 OUTSIDE REGULAR BUSINESS HOURS. (a) A contract to which this
41 subchapter applies must require the contracting Medicaid managed
42 care organization to reimburse a federally qualified health center
43 or rural health clinic for health care services provided to a
44 recipient outside of regular business hours, including on a weekend
45 or holiday, at a rate that is equal to the allowable rate for those
46 services as determined under Section 32.028, Human Resources Code,
47 if the recipient does not have a referral from the recipient's
48 primary care physician.

49 (b) The executive commissioner shall adopt rules regarding
50 the days, times of days, and holidays that are considered to be

1 outside of regular business hours for purposes of Subsection (a).
2 (Gov. Code, Secs. 533.005(a)(14), (c).)

3 Source Law

4 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
5 (a) A contract between a managed care organization
6 and the commission for the organization to provide
7 health care services to recipients must contain:]

8 . . .
9 (14) a requirement that the managed care
10 organization reimburse a federally qualified health
11 center or rural health clinic for health care services
12 provided to a recipient outside of regular business
13 hours, including on a weekend day or holiday, at a rate
14 that is equal to the allowable rate for those services
15 as determined under Section 32.028, Human Resources
16 Code, if the recipient does not have a referral from
17 the recipient's primary care physician;
18 . . .

19 (c) The executive commissioner shall adopt
20 rules regarding the days, times of days, and holidays
21 that are considered to be outside of regular business
22 hours for purposes of Subsection (a)(14).

23 Revised Law

24 Sec. 540.0267. PROVIDER APPEALS PROCESS. (a) A contract to
25 which this subchapter applies must require the contracting Medicaid
26 managed care organization to develop, implement, and maintain a
27 system for tracking and resolving provider appeals related to
28 claims payment. The system must include a process that requires:

29 (1) a tracking mechanism to document the status and
30 final disposition of each provider's claims payment appeal;

31 (2) contracting with physicians who are not network
32 providers and who are of the same or related specialty as the
33 appealing physician to resolve claims disputes that:

34 (A) relate to denial on the basis of medical
35 necessity; and

36 (B) remain unresolved after a provider appeal;

37 (3) the determination of the physician resolving the
38 dispute to be binding on the organization and provider; and

39 (4) the organization to allow a provider to initiate
40 an appeal of a claim that has not been paid before the time
41 prescribed by Section 540.0265(a)(1)(B).

42 (b) A contract to which this subchapter applies must require

1 the contracting Medicaid managed care organization to develop and
2 establish a process for responding to provider appeals in the
3 region in which the organization provides health care services.
4 (Gov. Code, Secs. 533.005(a)(15), (19).)

5 Source Law

6 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
7 (a) A contract between a managed care organization and
8 the commission for the organization to provide health
9 care services to recipients must contain:]

10 . . .
11 (15) a requirement that the managed care
12 organization develop, implement, and maintain a system
13 for tracking and resolving all provider appeals
14 related to claims payment, including a process that
15 will require:

16 (A) a tracking mechanism to document
17 the status and final disposition of each provider's
18 claims payment appeal;

19 (B) the contracting with physicians
20 who are not network providers and who are of the same
21 or related specialty as the appealing physician to
22 resolve claims disputes related to denial on the basis
23 of medical necessity that remain unresolved subsequent
24 to a provider appeal;

25 (C) the determination of the
26 physician resolving the dispute to be binding on the
27 managed care organization and provider; and

28 (D) the managed care organization to
29 allow a provider with a claim that has not been paid
30 before the time prescribed by Subdivision (7)(A)(ii)
31 to initiate an appeal of that claim;

32 . . .
33 (19) a requirement that the managed care
34 organization develop and establish a process for
35 responding to provider appeals in the region where the
36 organization provides health care services;
37 . . .

38 Revised Law

39 Sec. 540.0268. ASSISTANCE RESOLVING RECIPIENT AND PROVIDER
40 ISSUES. A contract to which this subchapter applies must require
41 the contracting Medicaid managed care organization to provide ready
42 access to a person who assists:

43 (1) a recipient in resolving issues relating to
44 enrollment, plan administration, education and training, access to
45 services, and grievance procedures; and

46 (2) a provider in resolving issues relating to
47 payment, plan administration, education and training, and
48 grievance procedures. (Gov. Code, Secs. 533.005(a)(3), (4).)

1 not be construed as authorizing a Medicaid managed care
2 organization to supervise or control the practice of medicine as
3 prohibited by Subtitle B, Title 3, Occupations Code. (Gov. Code,
4 Secs. 533.005(a)(13), (d).)

5 Source Law

6 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
7 (a) A contract between a managed care organization and
8 the commission for the organization to provide health
9 care services to recipients must contain:]

10 . . .
11 (13) a requirement that, notwithstanding
12 any other law, including Sections 843.312 and
13 1301.052, Insurance Code, the organization:

14 (A) use advanced practice registered
15 nurses and physician assistants in addition to
16 physicians as primary care providers to increase the
17 availability of primary care providers in the
18 organization's provider network; and

19 (B) treat advanced practice
20 registered nurses and physician assistants in the same
21 manner as primary care physicians with regard to:

22 (i) selection and assignment as
23 primary care providers;

24 (ii) inclusion as primary care
25 providers in the organization's provider network; and

26 (iii) inclusion as primary care
27 providers in any provider network directory maintained
28 by the organization;

29 . . .

30 (d) For purposes of Subsection (a)(13), an
31 advanced practice registered nurse may be included as
32 a primary care provider in a managed care
33 organization's provider network regardless of whether
34 the physician supervising the advanced practice
35 registered nurse is in the provider network. This
36 subsection may not be construed as authorizing a
37 managed care organization to supervise or control the
38 practice of medicine as prohibited by Subtitle B,
39 Title 3, Occupations Code.

40 Revised Law

41 Sec. 540.0270. MEDICAL DIRECTOR AVAILABILITY. A contract
42 to which this subchapter applies must require that a medical
43 director who is authorized to make medical necessity determinations
44 be available to the region in which the contracting Medicaid
45 managed care organization provides health care services. (Gov.
46 Code, Sec. 533.005(a)(16).)

47 Source Law

48 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
49 (a) A contract between a managed care organization
50 and the commission for the organization to provide
51 health care services to recipients must contain:]

52 . . .

1 (16) a requirement that a medical director
2 who is authorized to make medical necessity
3 determinations is available to the region where the
4 managed care organization provides health care
5 services;
6 . . .

7 Revised Law

8 Sec. 540.0271. PERSONNEL REQUIRED IN CERTAIN SERVICE
9 REGIONS. A contract to which this subchapter applies must require a
10 contracting Medicaid managed care organization that provides a
11 Medicaid managed care plan in the South Texas service region to
12 ensure the following personnel are located in that region:

- 13 (1) a medical director;
14 (2) patient care coordinators; and
15 (3) provider and recipient support services
16 personnel. (Gov. Code, Sec. 533.005(a)(17).)

17 Source Law

18 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
19 (a) A contract between a managed care organization and
20 the commission for the organization to provide health
21 care services to recipients must contain:]

22 . . .
23 (17) a requirement that the managed care
24 organization ensure that a medical director and
25 patient care coordinators and provider and recipient
26 support services personnel are located in the South
27 Texas service region, if the managed care organization
28 provides a managed care plan in that region;
29 . . .

30 Revised Law

31 Sec. 540.0272. CERTAIN SERVICES PERMITTED IN LIEU OF OTHER
32 MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES; ANNUAL REPORT. A
33 contract to which this subchapter applies must contain language
34 permitting the contracting Medicaid managed care organization to
35 offer medically appropriate, cost-effective, evidence-based
36 services from a list approved by the former state Medicaid managed
37 care advisory committee and included in the contract in lieu of
38 mental health or substance use disorder services specified in the
39 state Medicaid plan. A recipient is not required to use a service
40 from the list included in the contract in lieu of another mental
41 health or substance use disorder service specified in the state
42 Medicaid plan. The commission shall:

1 (1) prepare and submit to the legislature an annual
2 report on the number of times during the preceding year a service
3 from the list included in the contract is used; and

4 (2) consider the actual cost and use of any services
5 from the list included in the contract that are offered by a
6 Medicaid managed care organization when setting the capitation
7 rates for that organization under the contract. (Gov. Code, Sec.
8 533.005(h).)

9 Source Law

10 (h) In addition to the requirements specified by
11 Subsection (a), a contract described by that
12 subsection must contain language permitting a managed
13 care organization to offer medically appropriate,
14 cost-effective, evidence-based services from a list
15 approved by the state Medicaid managed care advisory
16 committee and included in the contract in lieu of
17 mental health or substance use disorder services
18 specified in the state Medicaid plan. A recipient is
19 not required to use a service from the list included in
20 the contract in lieu of another mental health or
21 substance use disorder service specified in the state
22 Medicaid plan. The commission shall:

23 (1) prepare and submit an annual report to
24 the legislature on the number of times during the
25 preceding year a service from the list included in the
26 contract is used; and

27 (2) take into consideration the actual
28 cost and use of any services from the list included in
29 the contract that are offered by a managed care
30 organization when setting the capitation rates for
31 that organization under the contract.

32 Revisor's Note

33 (1) Section 533.005(h), Government Code,
34 specifies certain language that must be included in a
35 contract under Section 533.005(a), Government Code,
36 that is "[i]n addition to the requirements specified
37 by Subsection (a)" of Section 533.005. The revised law
38 omits the quoted language as unnecessary because the
39 requirements specified by Section 533.005(a), which is
40 revised throughout this subchapter, apply by their own
41 terms and do not require a separate statement to that
42 effect.

43 (2) Section 533.005(h), Government Code,
44 references a list of services approved by the state

1 Medicaid managed care advisory committee. That
2 advisory committee will be abolished December 31,
3 2024, in accordance with 1 T.A.C. Section 351.805(i).
4 Because the effective date of the revised law is later
5 than the date the advisory committee is to be
6 abolished, the revised law refers to the "former"
7 state Medicaid managed care advisory committee.

8 Revised Law

9 Sec. 540.0273. OUTPATIENT PHARMACY BENEFIT PLAN. (a)
10 Subject to Subsection (b), a contract to which this subchapter
11 applies must require the contracting Medicaid managed care
12 organization to develop, implement, and maintain an outpatient
13 pharmacy benefit plan for the organization's enrolled recipients
14 that:

15 (1) except as provided by Section 540.0280(2),
16 exclusively employs the vendor drug program formulary and preserves
17 this state's ability to reduce Medicaid fraud, waste, and abuse;

18 (2) adheres to the applicable preferred drug list the
19 commission adopts under Section ____ [[[Section 531.072]]];

20 (3) except as provided by Section 540.0280(1),
21 includes the prior authorization procedures and requirements
22 prescribed by or implemented under Sections ____ [[[Sections
23 531.073(b), (c), and (g)]]] for the vendor drug program;

24 (4) does not require a clinical, nonpreferred, or
25 other prior authorization for any antiretroviral drug, as defined
26 by Section _____ [[[Section 531.073]]], or a step therapy or other
27 protocol, that could restrict or delay the dispensing of the drug
28 except to minimize fraud, waste, or abuse; and

29 (5) does not require prior authorization for a
30 nonpreferred antipsychotic drug prescribed to an adult recipient if
31 the requirements of Section _____ [[[Section 531.073(a-3)]]] are
32 met.

33 (b) The requirements imposed by Subsections (a)(1)-(3) do
34 not apply, and may not be enforced, on and after August 31, 2023.

1 (Gov. Code, Secs. 533.005(a)(23)(A), (B), (C), (C-1), (C-2),
2 (a-1).)

3 Source Law

4 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
5 (a) A contract between a managed care organization and
6 the commission for the organization to provide health
7 care services to recipients must contain:]

8
9 (23) subject to Subsection (a-1), a
10 requirement that the managed care organization
11 develop, implement, and maintain an outpatient
12 pharmacy benefit plan for its enrolled recipients:

13 (A) that, except as provided by
14 Paragraph (L)(ii), exclusively employs the vendor drug
15 program formulary and preserves the state's ability to
16 reduce waste, fraud, and abuse under Medicaid;

17 (B) that adheres to the applicable
18 preferred drug list adopted by the commission under
19 Section 531.072;

20 (C) that, except as provided by
21 Paragraph (L)(i), includes the prior authorization
22 procedures and requirements prescribed by or
23 implemented under Sections 531.073(b), (c), and (g)
24 for the vendor drug program;

25 (C-1) that does not require a
26 clinical, nonpreferred, or other prior authorization
27 for any antiretroviral drug, as defined by Section
28 531.073, or a step therapy or other protocol, that
29 could restrict or delay the dispensing of the drug
30 except to minimize fraud, waste, or abuse;

31 (C-2) that does not require prior
32 authorization for a nonpreferred antipsychotic drug
33 prescribed to an adult recipient if the requirements
34 of Section 531.073(a-3) are met;

35
36 (a-1) The requirements imposed by Subsections
37 (a)(23)(A), (B), and (C) do not apply, and may not be
38 enforced, on and after August 31, 2023.

39 Revised Law

40 Sec. 540.0274. PHARMACY BENEFIT PLAN: REBATES AND RECEIPT
41 OF CONFIDENTIAL INFORMATION PROHIBITED. A Medicaid managed care
42 organization, for purposes of the organization's outpatient
43 pharmacy benefit plan required by Section 540.0273 in a contract to
44 which this subchapter applies, may not:

45 (1) negotiate or collect rebates associated with
46 pharmacy products on the vendor drug program formulary; or

47 (2) receive drug rebate or pricing information that is
48 confidential under Section ____ [[[Section 531.071]]]. (Gov. Code,
49 Sec. 533.005(a)(23)(D).)

50 Source Law

51 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.

1 (a) A contract between a managed care organization and
2 the commission for the organization to provide health
3 care services to recipients must contain:

4 . . .
5 (23) . . . a requirement that the managed
6 care organization develop, implement, and maintain an
7 outpatient pharmacy benefit plan for its enrolled
8 recipients:]

9 . . .
10 (D) for purposes of which the managed
11 care organization:

12 (i) may not negotiate or
13 collect rebates associated with pharmacy products on
14 the vendor drug program formulary; and

15 (ii) may not receive drug
16 rebate or pricing information that is confidential
17 under Section 531.071;

18 . . .

19 Revised Law

20 Sec. 540.0275. PHARMACY BENEFIT PLAN: CERTAIN PHARMACY
21 BENEFITS FOR SEX OFFENDERS PROHIBITED. A Medicaid managed care
22 organization's pharmacy benefit plan required by Section 540.0273
23 in a contract to which this subchapter applies must comply with the
24 prohibition under Section ____ [[[Section 531.089]]]. (Gov. Code,
25 Sec. 533.005(a)(23)(E).)

26 Source Law

27 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
28 (a) A contract between a managed care organization and
29 the commission for the organization to provide health
30 care services to recipients must contain:

31 . . .
32 (23) . . . a requirement that the managed
33 care organization develop, implement, and maintain an
34 outpatient pharmacy benefit plan for its enrolled
35 recipients:]

36 . . .
37 (E) that complies with the
38 prohibition under Section 531.089;

39 . . .

40 Revised Law

41 Sec. 540.0276. PHARMACY BENEFIT PLAN: RECIPIENT SELECTION
42 OF PHARMACEUTICAL SERVICES PROVIDER. A Medicaid managed care
43 organization, under the organization's pharmacy benefit plan
44 required by Section 540.0273 in a contract to which this subchapter
45 applies, may not prohibit, limit, or interfere with a recipient's
46 selection of a pharmacy or pharmacist of the recipient's choice to
47 provide pharmaceutical services under the plan by imposing
48 different copayments. (Gov. Code, Sec. 533.005(a)(23)(F).)

1 comply with the financial terms, as well as other reasonable
2 administrative and professional terms, of the contract;

3 (2) may include mail-order pharmacies in the
4 organization's networks, but may not require enrolled recipients to
5 use those pharmacies; and

6 (3) may not charge an enrolled recipient who opts to
7 use a mail-order pharmacy a fee, including a postage or handling
8 fee. (Gov. Code, Secs. 533.005(a)(23)(G), (H), (I).)

9 Source Law

10 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
11 (a) A contract between a managed care organization and
12 the commission for the organization to provide health
13 care services to recipients must contain:

14 . . .
15 (23) . . . a requirement that the managed
16 care organization develop, implement, and maintain an
17 outpatient pharmacy benefit plan for its enrolled
18 recipients:]

19 . . .
20 (G) that allows the managed care
21 organization or any subcontracted pharmacy benefit
22 manager to contract with a pharmacist or pharmacy
23 providers separately for specialty pharmacy services,
24 except that:

25 (i) the managed care
26 organization and pharmacy benefit manager are
27 prohibited from allowing exclusive contracts with a
28 specialty pharmacy owned wholly or partly by the
29 pharmacy benefit manager responsible for the
30 administration of the pharmacy benefit program; and

31 (ii) the managed care
32 organization and pharmacy benefit manager must adopt
33 policies and procedures for reclassifying
34 prescription drugs from retail to specialty drugs, and
35 those policies and procedures must be consistent with
36 rules adopted by the executive commissioner and
37 include notice to network pharmacy providers from the
38 managed care organization;

39 (H) under which the managed care
40 organization may not prevent a pharmacy or pharmacist
41 from participating as a provider if the pharmacy or
42 pharmacist agrees to comply with the financial terms
43 and conditions of the contract as well as other
44 reasonable administrative and professional terms and
45 conditions of the contract;

46 (I) under which the managed care
47 organization may include mail-order pharmacies in its
48 networks, but may not require enrolled recipients to
49 use those pharmacies, and may not charge an enrolled
50 recipient who opts to use this service a fee, including
51 postage and handling fees;

52 . . .

53 Revisor's Note

54 (1) Section 533.005(a)(23)(G)(i), Government
55 Code, refers to a Medicaid managed care organization's

1 pharmacy benefit "program." The revised law
2 substitutes the term "plan" for "program" for
3 consistency of terminology throughout this
4 subchapter.

5 (2) Section 533.005(a)(23)(H), Government Code,
6 refers to a pharmacy or pharmacist's agreement to
7 comply with "terms and conditions" of a contract
8 between a Medicaid managed care organization or
9 pharmacy benefit manager and the pharmacy or
10 pharmacist. The revised law omits "conditions" from
11 the quoted phrase for the reason stated in Revisor's
12 Note (3) to Section 540.0206.

13 Revised Law

14 Sec. 540.0278. PHARMACY BENEFIT PLAN: PROMPT PAYMENT OF
15 PHARMACY BENEFIT CLAIMS. A Medicaid managed care organization or
16 pharmacy benefit manager, as applicable, under the organization's
17 pharmacy benefit plan required by Section 540.0273 in a contract to
18 which this subchapter applies, must pay claims in accordance with
19 Section 843.339, Insurance Code. (Gov. Code, Sec.
20 533.005(a)(23)(J).)

21 Source Law

22 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
23 (a) A contract between a managed care organization and
24 the commission for the organization to provide health
25 care services to recipients must contain:

26 . . .
27 (23) . . . a requirement that the managed
28 care organization develop, implement, and maintain an
29 outpatient pharmacy benefit plan for its enrolled
30 recipients:]

31 . . .
32 (J) under which the managed care
33 organization or pharmacy benefit manager, as
34 applicable, must pay claims in accordance with Section
35 843.339, Insurance Code;
36 . . .

37 Revised Law

38 Sec. 540.0279. PHARMACY BENEFIT PLAN: MAXIMUM ALLOWABLE
39 COST PRICE AND LIST FOR PHARMACY BENEFITS. (a) A Medicaid managed
40 care organization or pharmacy benefit manager, as applicable, under
41 the organization's pharmacy benefit plan required by Section

1 540.0273 in a contract to which this subchapter applies, must:

2 (1) ensure that, to place a drug on a maximum allowable
3 cost list:

4 (A) the drug is listed as "A" or "B" rated in the
5 most recent version of the United States Food and Drug
6 Administration's Approved Drug Products with Therapeutic
7 Equivalence Evaluations, also known as the Orange Book, has an "NR"
8 or "NA" rating or a similar rating by a nationally recognized
9 reference; and

10 (B) the drug is generally available for purchase
11 by pharmacies in this state from national or regional wholesalers
12 and is not obsolete;

13 (2) review and update maximum allowable cost price
14 information at least once every seven days to reflect any maximum
15 allowable cost pricing modification;

16 (3) in formulating a drug's maximum allowable cost
17 price, use only the price of the drug and drugs listed as
18 therapeutically equivalent in the most recent version of the United
19 States Food and Drug Administration's Approved Drug Products with
20 Therapeutic Equivalence Evaluations, also known as the Orange Book;

21 (4) establish a process for eliminating products from
22 the maximum allowable cost list or modifying maximum allowable cost
23 prices in a timely manner to remain consistent with pricing changes
24 and product availability in the marketplace; and

25 (5) notify the commission not later than the 21st day
26 after implementing a practice of using a maximum allowable cost
27 list for drugs dispensed at retail but not by mail.

28 (b) A Medicaid managed care organization or pharmacy
29 benefit manager, as applicable, under the organization's pharmacy
30 benefit plan required by Section 540.0273 in a contract to which
31 this subchapter applies, must:

32 (1) provide a procedure for a network pharmacy
33 provider to challenge a drug's listed maximum allowable cost price;

34 (2) respond to a challenge not later than the 15th day

1 after the date the provider makes the challenge;

2 (3) if the challenge is successful, adjust the drug
3 price effective on the date the challenge is resolved and make the
4 adjustment applicable to all similarly situated network pharmacy
5 providers, as the Medicaid managed care organization or pharmacy
6 benefit manager, as appropriate, determines;

7 (4) if the challenge is denied, provide the reason for
8 the denial; and

9 (5) report to the commission every 90 days the total
10 number of challenges that were made and denied in the preceding
11 90-day period for each maximum allowable cost list drug for which a
12 challenge was denied during the period.

13 (c) A Medicaid managed care organization or pharmacy
14 benefit manager, as applicable, under the organization's pharmacy
15 benefit plan required by Section 540.0273 in a contract to which
16 this subchapter applies, must provide:

17 (1) to a network pharmacy provider, at the time the
18 organization or pharmacy benefit manager enters into or renews a
19 contract with the provider, the sources used to determine the
20 maximum allowable cost pricing for the maximum allowable cost list
21 specific to that provider; and

22 (2) a process for each network pharmacy provider to
23 readily access the maximum allowable cost list specific to that
24 provider.

25 (d) Except as provided by Subsection (c)(2), a maximum
26 allowable cost list specific to a provider that a Medicaid managed
27 care organization or pharmacy benefit manager maintains is
28 confidential. (Gov. Code, Secs. 533.005(a)(23)(K), (a-2).)

29 Source Law

30 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
31 (a) A contract between a managed care organization and
32 the commission for the organization to provide health
33 care services to recipients must contain:

34 . . .
35 (23) subject to Subsection (a-1), a
36 requirement that the managed care organization
37 develop, implement, and maintain an outpatient
38 pharmacy benefit plan for its enrolled recipients:]

1
2 (K) under which the managed care
3 organization or pharmacy benefit manager, as
4 applicable:

5 (i) to place a drug on a maximum
6 allowable cost list, must ensure that:

7 (a) the drug is listed as
8 "A" or "B" rated in the most recent version of the
9 United States Food and Drug Administration's Approved
10 Drug Products with Therapeutic Equivalence
11 Evaluations, also known as the Orange Book, has an "NR"
12 or "NA" rating or a similar rating by a nationally
13 recognized reference; and

14 (b) the drug is generally
15 available for purchase by pharmacies in the state from
16 national or regional wholesalers and is not obsolete;

17 (ii) must provide to a network
18 pharmacy provider, at the time a contract is entered
19 into or renewed with the network pharmacy provider,
20 the sources used to determine the maximum allowable
21 cost pricing for the maximum allowable cost list
22 specific to that provider;

23 (iii) must review and update
24 maximum allowable cost price information at least once
25 every seven days to reflect any modification of
26 maximum allowable cost pricing;

27 (iv) must, in formulating the
28 maximum allowable cost price for a drug, use only the
29 price of the drug and drugs listed as therapeutically
30 equivalent in the most recent version of the United
31 States Food and Drug Administration's Approved Drug
32 Products with Therapeutic Equivalence Evaluations,
33 also known as the Orange Book;

34 (v) must establish a process
35 for eliminating products from the maximum allowable
36 cost list or modifying maximum allowable cost prices
37 in a timely manner to remain consistent with pricing
38 changes and product availability in the marketplace;

39 (vi) must:

40 (a) provide a procedure
41 under which a network pharmacy provider may challenge
42 a listed maximum allowable cost price for a drug;

43 (b) respond to a challenge
44 not later than the 15th day after the date the
45 challenge is made;

46 (c) if the challenge is
47 successful, make an adjustment in the drug price
48 effective on the date the challenge is resolved and
49 make the adjustment applicable to all similarly
50 situated network pharmacy providers, as determined by
51 the managed care organization or pharmacy benefit
52 manager, as appropriate;

53 (d) if the challenge is
54 denied, provide the reason for the denial; and

55 (e) report to the
56 commission every 90 days the total number of
57 challenges that were made and denied in the preceding
58 90-day period for each maximum allowable cost list
59 drug for which a challenge was denied during the
60 period;

61 (vii) must notify the
62 commission not later than the 21st day after
63 implementing a practice of using a maximum allowable
64 cost list for drugs dispensed at retail but not by
65 mail; and

66 (viii) must provide a process
67 for each of its network pharmacy providers to readily
68 access the maximum allowable cost list specific to

1 that provider; and
2 . . .

3 (a-2) Except as provided by Subsection
4 (a)(23)(K)(viii), a maximum allowable cost list
5 specific to a provider and maintained by a managed care
6 organization or pharmacy benefit manager is
7 confidential.

8 Revised Law

9 Sec. 540.0280. PHARMACY BENEFIT PLAN: PHARMACY BENEFITS FOR
10 CHILD ENROLLED IN STAR KIDS MANAGED CARE PROGRAM. A Medicaid
11 managed care organization or pharmacy benefit manager, as
12 applicable, under the organization's pharmacy benefit plan
13 required by Section 540.0273 in a contract to which this subchapter
14 applies:

15 (1) may not require a prior authorization, other than
16 a clinical prior authorization or a prior authorization the
17 commission imposes to minimize the opportunity for fraud, waste, or
18 abuse, for or impose any other barriers to a drug that is prescribed
19 to a child enrolled in the STAR Kids managed care program for a
20 particular disease or treatment and that is on the vendor drug
21 program formulary or require additional prior authorization for a
22 drug included in the preferred drug list the commission adopts
23 under Section _____ [[[Section 531.072]]];

24 (2) must provide continued access to a drug prescribed
25 to a child enrolled in the STAR Kids managed care program,
26 regardless of whether the drug is on the vendor drug program
27 formulary or, if applicable on or after August 31, 2023, the
28 organization's formulary;

29 (3) may not use a protocol that requires a child
30 enrolled in the STAR Kids managed care program to use a prescription
31 drug or sequence of prescription drugs other than the drug the
32 child's physician recommends for the child's treatment before the
33 organization will cover the recommended drug; and

34 (4) must pay liquidated damages to the commission for
35 each failure, as the commission determines, to comply with this
36 section in an amount that is a reasonable forecast of the damages
37 caused by the noncompliance. (Gov. Code, Sec. 533.005(a)(23)(L).)

1 Source Law

2 [Sec. 533.005. REQUIRED CONTRACT PROVISIONS.
3 (a) A contract between a managed care organization and
4 the commission for the organization to provide health
5 care services to recipients must contain:

6 . . .
7 (23) subject to Subsection (a-1), a
8 requirement that the managed care organization
9 develop, implement, and maintain an outpatient
10 pharmacy benefit plan for its enrolled recipients:]

11 . . .
12 (L) under which the managed care
13 organization or pharmacy benefit manager, as
14 applicable:

15 (i) may not require a prior
16 authorization, other than a clinical prior
17 authorization or a prior authorization imposed by the
18 commission to minimize the opportunity for waste,
19 fraud, or abuse, for or impose any other barriers to a
20 drug that is prescribed to a child enrolled in the STAR
21 Kids managed care program for a particular disease or
22 treatment and that is on the vendor drug program
23 formulary or require additional prior authorization
24 for a drug included in the preferred drug list adopted
25 under Section 531.072;

26 (ii) must provide for continued
27 access to a drug prescribed to a child enrolled in the
28 STAR Kids managed care program, regardless of whether
29 the drug is on the vendor drug program formulary or, if
30 applicable on or after August 31, 2023, the managed
31 care organization's formulary;

32 (iii) may not use a protocol
33 that requires a child enrolled in the STAR Kids managed
34 care program to use a prescription drug or sequence of
35 prescription drugs other than the drug that the child's
36 physician recommends for the child's treatment before
37 the managed care organization provides coverage for
38 the recommended drug; and

39 (iv) must pay liquidated
40 damages to the commission for each failure, as
41 determined by the commission, to comply with this
42 paragraph in an amount that is a reasonable forecast of
43 the damages caused by the noncompliance;

44 . . .

45 SUBCHAPTER G. PRIOR AUTHORIZATION AND UTILIZATION REVIEW

46 PROCEDURES

47 Revised Law

48 Sec. 540.0301. INAPPLICABILITY OF CERTAIN OTHER LAW TO
49 MEDICAID MANAGED CARE UTILIZATION REVIEWS. Section
50 4201.304(a)(2), Insurance Code, does not apply to a Medicaid
51 managed care organization or a utilization review agent who
52 conducts utilization reviews for a Medicaid managed care
53 organization. (Gov. Code, Sec. 533.00282(a).)

54 Source Law

55 Sec. 533.00282. UTILIZATION REVIEW AND PRIOR

1 AUTHORIZATION PROCEDURES. (a) Section
2 4201.304(a)(2), Insurance Code, does not apply to a
3 Medicaid managed care organization or a utilization
4 review agent who conducts utilization reviews for a
5 Medicaid managed care organization.

6 Revised Law

7 Sec. 540.0302. PRIOR AUTHORIZATION PROCEDURES FOR
8 HOSPITALIZED RECIPIENT. (a) This section applies only to a prior
9 authorization request submitted with respect to a recipient who is
10 hospitalized at the time of the request.

11 (b) In addition to the requirements of Subchapter F, a
12 contract between a Medicaid managed care organization and the
13 commission to which that subchapter applies must require that,
14 notwithstanding any other law, the organization review and issue a
15 determination on a prior authorization request to which this
16 section applies according to the following time frames:

17 (1) within one business day after the organization
18 receives the request, except as provided by Subdivisions (2) and
19 (3);

20 (2) within 72 hours after the organization receives
21 the request if a provider of acute care inpatient services submits
22 the request and the request is for services or equipment necessary
23 to discharge the recipient from an inpatient facility; or

24 (3) within one hour after the organization receives
25 the request if the request is related to poststabilization care or a
26 life-threatening condition. (Gov. Code, Sec. 533.002821.)

27 Source Law

28 Sec. 533.002821. PRIOR AUTHORIZATION
29 PROCEDURES FOR HOSPITALIZED RECIPIENT. In addition to
30 the requirements of Section 533.005, a contract
31 between a managed care organization and the commission
32 described by that section must require that,
33 notwithstanding any other law, the organization review
34 and issue determinations on prior authorization
35 requests with respect to a recipient who is
36 hospitalized at the time of the request according to
37 the following time frames:

38 (1) within one business day after
39 receiving the request, except as provided by
40 Subdivisions (2) and (3);

41 (2) within 72 hours after receiving the
42 request if the request is submitted by a provider of
43 acute care inpatient services for services or
44 equipment necessary to discharge the recipient from an
45 inpatient facility; or

1 (3) within one hour after receiving the
2 request if the request is related to poststabilization
3 care or a life-threatening condition.

4 Revisor's Note

5 Section 533.002821, Government Code, refers to
6 the "requirements of Section 533.005," Government
7 Code, meaning the required provisions in a contract
8 between a Medicaid managed care organization and the
9 Health and Human Services Commission for the
10 organization to provide health care services to
11 Medicaid recipients. The required contract provisions
12 of Section 533.005 are revised in this chapter as
13 Subchapter F. Accordingly, the revised law throughout
14 this subchapter substitutes a reference to the
15 "requirements of Subchapter F" for the quoted phrase.

16 Revised Law

17 Sec. 540.0303. PRIOR AUTHORIZATION PROCEDURES FOR
18 NONHOSPITALIZED RECIPIENT. (a) This section applies only to a
19 prior authorization request submitted with respect to a recipient
20 who is not hospitalized at the time of the request.

21 (b) In addition to the requirements of Subchapter F, a
22 contract between a Medicaid managed care organization and the
23 commission to which that subchapter applies must require that the
24 organization review and issue a determination on a prior
25 authorization request to which this section applies according to
26 the following time frames:

27 (1) within three business days after the organization
28 receives the request; or

29 (2) within the time frame and following the process
30 the commission establishes if the organization receives a prior
31 authorization request that does not include sufficient or adequate
32 documentation.

33 (c) The commission shall establish a process for use by a
34 Medicaid managed care organization that receives a prior
35 authorization request to which this section applies that does not

1 include sufficient or adequate documentation. The process must
2 provide a time frame within which a provider may submit the
3 necessary documentation. The time frame must be longer than the
4 time frame specified by Subsection (b)(1). (Gov. Code, Secs.
5 533.00282(b) (part), (c).)

6 Source Law

7 (b) In addition to the requirements of Section
8 533.005, a contract between a Medicaid managed care
9 organization and the commission must require that:

10 . . .
11 (2) the organization review and issue
12 determinations on prior authorization requests with
13 respect to a recipient who is not hospitalized at the
14 time of the request according to the following time
15 frames:

16 (A) within three business days after
17 receiving the request; or

18 (B) within the time frame and
19 following the process established by the commission if
20 the organization receives a request for prior
21 authorization that does not include sufficient or
22 adequate documentation.

23 (c) In consultation with the state Medicaid
24 managed care advisory committee, the commission shall
25 establish a process for use by a Medicaid managed care
26 organization that receives a prior authorization
27 request, with respect to a recipient who is not
28 hospitalized at the time of the request, that does not
29 include sufficient or adequate documentation. The
30 process must provide a time frame within which a
31 provider may submit the necessary documentation. The
32 time frame must be longer than the time frame specified
33 by Subsection (b)(2)(A) within which a Medicaid
34 managed care organization must issue a determination
35 on a prior authorization request.

36 Revisor's Note

37 Section 533.00282(c), Government Code, requires
38 the Health and Human Services Commission to consult
39 with the state Medicaid managed care advisory
40 committee. As stated in Revisor's Note (2) to Section
41 540.0272 of this chapter, that advisory committee will
42 be abolished December 31, 2024. Because the effective
43 date of the revised law is later than the date the
44 advisory committee is to be abolished, the revised law
45 omits the requirement to consult with the advisory
46 committee.

47 Revised Law

48 Sec. 540.0304. ANNUAL REVIEW OF PRIOR AUTHORIZATION

1 REQUIREMENTS. (a) Each Medicaid managed care organization, in
2 consultation with the organization's provider advisory group
3 required by contract, shall develop and implement a process for
4 conducting an annual review of the organization's prior
5 authorization requirements. The annual review process does not
6 apply to a prior authorization requirement prescribed by or
7 implemented under Section _____ [[[Section 531.073]]] for the
8 vendor drug program.

9 (b) In conducting an annual review, a Medicaid managed care
10 organization must:

11 (1) solicit, receive, and consider input from
12 providers in the organization's provider network; and

13 (2) ensure that each prior authorization requirement
14 is based on accurate, up-to-date, evidence-based, and
15 peer-reviewed clinical criteria that, as appropriate, distinguish
16 between categories of recipients for whom prior authorization
17 requests are submitted, including age categories.

18 (c) A Medicaid managed care organization may not impose a
19 prior authorization requirement, other than a prior authorization
20 requirement prescribed by or implemented under Section _____
21 [[[Section 531.073]]] for the vendor drug program, unless the
22 organization reviewed the requirement during the most recent annual
23 review.

24 (d) The commission shall periodically review each Medicaid
25 managed care organization to ensure the organization's compliance
26 with this section. (Gov. Code, Sec. 533.00283.)

27 Source Law

28 Sec. 533.00283. ANNUAL REVIEW OF PRIOR
29 AUTHORIZATION REQUIREMENTS. (a) Each Medicaid managed
30 care organization, in consultation with the
31 organization's provider advisory group required by
32 contract, shall develop and implement a process to
33 conduct an annual review of the organization's prior
34 authorization requirements, other than a prior
35 authorization requirement prescribed by or
36 implemented under Section 531.073 for the vendor drug
37 program. In conducting a review, the organization
38 must:

39 (1) solicit, receive, and consider input
40 from providers in the organization's provider network;

1 and

2 (2) ensure that each prior authorization
3 requirement is based on accurate, up-to-date,
4 evidence-based, and peer-reviewed clinical criteria
5 that distinguish, as appropriate, between categories,
6 including age, of recipients for whom prior
7 authorization requests are submitted.

8 (b) A Medicaid managed care organization may not
9 impose a prior authorization requirement, other than a
10 prior authorization requirement prescribed by or
11 implemented under Section 531.073 for the vendor drug
12 program, unless the organization has reviewed the
13 requirement during the most recent annual review
14 required under this section.

15 (c) The commission shall periodically review
16 each Medicaid managed care organization to ensure the
17 organization's compliance with this section.

18 Revised Law

19 Sec. 540.0305. PHYSICIAN CONSULTATION BEFORE ADVERSE PRIOR
20 AUTHORIZATION DETERMINATION. In addition to the requirements of
21 Subchapter F, a contract between a Medicaid managed care
22 organization and the commission to which that subchapter applies
23 must require that, before issuing an adverse determination on a
24 prior authorization request, the organization provide the
25 physician requesting the prior authorization with a reasonable
26 opportunity to discuss the request with another physician who:

27 (1) practices in the same or a similar specialty, but
28 not necessarily the same subspecialty; and

29 (2) has experience in treating the same category of
30 population as the recipient on whose behalf the physician submitted
31 the request. (Gov. Code, Sec. 533.00282(b) (part).)

32 Source Law

33 (b) In addition to the requirements of Section
34 533.005, a contract between a Medicaid managed care
35 organization and the commission must require that:

36 (1) before issuing an adverse
37 determination on a prior authorization request, the
38 organization provide the physician requesting the
39 prior authorization with a reasonable opportunity to
40 discuss the request with another physician who
41 practices in the same or a similar specialty, but not
42 necessarily the same subspecialty, and has experience
43 in treating the same category of population as the
44 recipient on whose behalf the request is submitted;
45 and

46 . . .

47 Revised Law

48 Sec. 540.0306. RECONSIDERATION FOLLOWING ADVERSE
49 DETERMINATIONS ON CERTAIN PRIOR AUTHORIZATION REQUESTS. (a) The

1 commission shall establish a uniform process and timeline for a
2 Medicaid managed care organization to reconsider an adverse
3 determination on a prior authorization request that resulted solely
4 from the submission of insufficient or inadequate documentation. In
5 addition to the requirements of Subchapter F, a contract between a
6 Medicaid managed care organization and the commission to which that
7 subchapter applies must include a requirement that the organization
8 implement the process and timeline.

9 (b) The process and timeline must:

10 (1) allow a provider to submit any documentation
11 identified as insufficient or inadequate in the notice provided
12 under Section _____ [[[Section 531.024162]]];

13 (2) allow the provider requesting the prior
14 authorization to discuss the request with another provider who:

15 (A) practices in the same or a similar specialty,
16 but not necessarily the same subspecialty; and

17 (B) has experience in treating the same category
18 of population as the recipient on whose behalf the provider
19 submitted the request; and

20 (3) require the Medicaid managed care organization to
21 amend the determination on the prior authorization request as
22 necessary, considering the additional documentation.

23 (c) An adverse determination on a prior authorization
24 request is considered a denial of services in an evaluation of the
25 Medicaid managed care organization only if the determination is not
26 amended under Subsection (b)(3) to approve the request.

27 (d) The process and timeline for reconsidering an adverse
28 determination on a prior authorization request under this section
29 do not affect:

30 (1) any related timelines, including the timeline for
31 an internal appeal, a Medicaid fair hearing, or a review conducted
32 by an external medical reviewer; or

33 (2) any rights of a recipient to appeal a
34 determination on a prior authorization request. (Gov. Code, Sec.

1 533.00284.)

2 Source Law

3 Sec. 533.00284. RECONSIDERATION FOLLOWING
4 ADVERSE DETERMINATIONS ON CERTAIN PRIOR AUTHORIZATION
5 REQUESTS. (a) In consultation with the state Medicaid
6 managed care advisory committee, the commission shall
7 establish a uniform process and timeline for Medicaid
8 managed care organizations to reconsider an adverse
9 determination on a prior authorization request that
10 resulted solely from the submission of insufficient or
11 inadequate documentation. In addition to the
12 requirements of Section 533.005, a contract between a
13 Medicaid managed care organization and the commission
14 must include a requirement that the organization
15 implement the process and timeline.

16 (b) The process and timeline must:

17 (1) allow a provider to submit any
18 documentation that was identified as insufficient or
19 inadequate in the notice provided under Section
20 531.024162;

21 (2) allow the provider requesting the
22 prior authorization to discuss the request with
23 another provider who practices in the same or a similar
24 specialty, but not necessarily the same subspecialty,
25 and has experience in treating the same category of
26 population as the recipient on whose behalf the
27 request is submitted; and

28 (3) require the Medicaid managed care
29 organization to amend the determination on the prior
30 authorization request as necessary, considering the
31 additional documentation.

32 (c) An adverse determination on a prior
33 authorization request is considered a denial of
34 services in an evaluation of the Medicaid managed care
35 organization only if the determination is not amended
36 under Subsection (b)(3) to approve the request.

37 (d) The process and timeline for reconsidering
38 an adverse determination on a prior authorization
39 request under this section do not affect:

40 (1) any related timelines, including the
41 timeline for an internal appeal, a Medicaid fair
42 hearing, or a review conducted by an external medical
43 reviewer; or

44 (2) any rights of a recipient to appeal a
45 determination on a prior authorization request.

46 Revisor's Note

47 Section 533.00284(a), Government Code, requires
48 the Health and Human Services Commission to consult
49 with the state Medicaid managed care advisory
50 committee. The revised law omits the requirement to
51 consult with the advisory committee for the reason
52 stated in the revisor's note to Section 540.0303 of
53 this chapter.

54 Revised Law

55 Sec. 540.0307. MAXIMUM PERIOD FOR PRIOR AUTHORIZATION

1 DECISION; ACCESS TO CARE. The combined amount of time provided for
2 the time frames prescribed by the utilization review and prior
3 authorization procedures described by Sections 540.0301, 540.0303,
4 and 540.0305 and the timeline for reconsidering an adverse
5 determination on a prior authorization described by Section
6 540.0306 may not exceed the time frame for a decision under
7 federally prescribed time frames. It is the intent of the
8 legislature that these provisions allow sufficient time to provide
9 necessary documentation and avoid unnecessary denials without
10 delaying access to care. (Gov. Code, Sec. 533.002841.)

11 Source Law

12 Sec. 533.002841. MAXIMUM PERIOD FOR PRIOR
13 AUTHORIZATION DECISION; ACCESS TO CARE. The time
14 frames prescribed by the utilization review and prior
15 authorization procedures described by Section
16 533.00282 and the timeline for reconsidering an
17 adverse determination on a prior authorization
18 described by Section 533.00284 together may not exceed
19 the time frame for a decision under federally
20 prescribed time frames. It is the intent of the
21 legislature that these provisions allow sufficient
22 time to provide necessary documentation and avoid
23 unnecessary denials without delaying access to care.

24 SUBCHAPTER H. PREMIUM PAYMENT RATES

25 Revised Law

26 Sec. 540.0351. PREMIUM PAYMENT RATE DETERMINATION. (a) In
27 determining premium payment rates paid to a managed care
28 organization under a managed care plan, the commission shall
29 consider:

30 (1) the regional variation in health care service
31 costs;

32 (2) the range and type of health care services that
33 premium payment rates are to cover;

34 (3) the number of managed care plans in a region;

35 (4) the current and projected number of recipients in
36 each region, including the current and projected number for each
37 category of recipient;

38 (5) the managed care plan's ability to meet operating
39 costs under the proposed premium payment rates;

1 (6) the requirements of the Balanced Budget Act of
2 1997 (Pub. L. No. 105-33) and implementing regulations that require
3 adequacy of premium payments to Medicaid managed care
4 organizations;

5 (7) the adequacy of the management fee paid for
6 assisting enrollees of Supplemental Security Income (SSI) (42
7 U.S.C. Section 1381 et seq.) who are voluntarily enrolled in the
8 managed care plan;

9 (8) the impact of reducing premium payment rates for
10 the category of pregnant recipients; and

11 (9) the managed care plan's ability under the proposed
12 premium payment rates to pay inpatient and outpatient hospital
13 provider payment rates that are comparable to the inpatient and
14 outpatient hospital provider payment rates the commission pays
15 under a primary care case management model or a partially capitated
16 model.

17 (b) The premium payment rates paid to a managed care
18 organization that holds a certificate of authority issued under
19 Chapter 843, Insurance Code, must be established by a competitive
20 bid process but may not exceed the maximum premium payment rates the
21 commission establishes under Section 540.0352(b).

22 (c) The commission shall pursue and, if appropriate,
23 implement premium rate-setting strategies that encourage provider
24 payment reform and more efficient service delivery and provider
25 practices. In pursuing the strategies, the commission shall review
26 and consider strategies employed or under consideration by other
27 states. If necessary, the commission may request a waiver or other
28 authorization from a federal agency to implement strategies the
29 commission identifies under this subsection. (Gov. Code, Secs.
30 533.013(a), (c), (e).)

31 Source Law

32 Sec. 533.013. PREMIUM PAYMENT RATE
33 DETERMINATION; REVIEW AND COMMENT. (a) In
34 determining premium payment rates paid to a managed
35 care organization under a managed care plan, the
36 commission shall consider:

1 (1) the regional variation in costs of
2 health care services;

3 (2) the range and type of health care
4 services to be covered by premium payment rates;

5 (3) the number of managed care plans in a
6 region;

7 (4) the current and projected number of
8 recipients in each region, including the current and
9 projected number for each category of recipient;

10 (5) the ability of the managed care plan to
11 meet costs of operation under the proposed premium
12 payment rates;

13 (6) the applicable requirements of the
14 federal Balanced Budget Act of 1997 and implementing
15 regulations that require adequacy of premium payments
16 to managed care organizations participating in
17 Medicaid;

18 (7) the adequacy of the management fee
19 paid for assisting enrollees of Supplemental Security
20 Income (SSI) (42 U.S.C. Section 1381 et seq.) who are
21 voluntarily enrolled in the managed care plan;

22 (8) the impact of reducing premium payment
23 rates for the category of recipients who are pregnant;
24 and

25 (9) the ability of the managed care plan to
26 pay under the proposed premium payment rates inpatient
27 and outpatient hospital provider payment rates that
28 are comparable to the inpatient and outpatient
29 hospital provider payment rates paid by the commission
30 under a primary care case management model or a
31 partially capitated model.

32 (c) The premium payment rates paid to a managed
33 care organization that is licensed under Chapter 843,
34 Insurance Code, shall be established by a competitive
35 bid process but may not exceed the maximum premium
36 payment rates established by the commission under
37 Subsection (b).

38 (e) The commission shall pursue and, if
39 appropriate, implement premium rate-setting
40 strategies that encourage provider payment reform and
41 more efficient service delivery and provider
42 practices. In pursuing premium rate-setting
43 strategies under this section, the commission shall
44 review and consider strategies employed or under
45 consideration by other states. If necessary, the
46 commission may request a waiver or other authorization
47 from a federal agency to implement strategies
48 identified under this subsection.

49 Revisor's Note

50 Section 533.013(c), Government Code, refers to a
51 managed care organization that "is licensed" under
52 Chapter 843, Insurance Code. The revised law
53 substitutes "holds a certificate of authority" for the
54 quoted language for the reason stated in Revisor's Note
55 (2) to Section 540.0206 of this chapter.

56 Revised Law

57 Sec. 540.0352. MAXIMUM PREMIUM PAYMENT RATES FOR CERTAIN

1 PROGRAMS. (a) This section applies only to a Medicaid managed care
2 organization that holds a certificate of authority issued under
3 Chapter 843, Insurance Code, and with respect to Medicaid managed
4 care pilot programs, Medicaid behavioral health pilot programs, and
5 Medicaid STAR+PLUS pilot programs implemented in a health care
6 service region after June 1, 1999.

7 (b) In determining the maximum premium payment rates paid to
8 a Medicaid managed care organization to which this section applies,
9 the commission shall consider and adjust for the regional variation
10 in costs of services under the traditional fee-for-service
11 component of Medicaid, utilization patterns, and other factors that
12 influence the potential for cost savings. For a service area with a
13 service area factor of .93 or less, or another appropriate service
14 area factor, as the commission determines, the commission may not
15 discount premium payment rates in an amount that is more than the
16 amount necessary to meet federal budget neutrality requirements for
17 projected fee-for-service costs unless:

18 (1) a historical review of managed care financial
19 results among managed care organizations in the service area the
20 organization serves demonstrates that additional savings are
21 warranted; or

22 (2) a review of Medicaid fee-for-service delivery in
23 the service area the organization serves has historically shown:

24 (A) significant recipient overutilization of
25 certain services covered by the premium payment rates in comparison
26 to utilization patterns throughout the rest of this state; or

27 (B) an above-market cost for services for which
28 there is substantial evidence that Medicaid managed care delivery
29 will reduce the cost of those services. (Gov. Code, Secs.
30 533.013(b), (d).)

31 Source Law

32 (b) In determining the maximum premium payment
33 rates paid to a managed care organization that is
34 licensed under Chapter 843, Insurance Code, the
35 commission shall consider and adjust for the regional
36 variation in costs of services under the traditional

1 fee-for-service component of Medicaid, utilization
2 patterns, and other factors that influence the
3 potential for cost savings. For a service area with a
4 service area factor of .93 or less, or another
5 appropriate service area factor, as determined by the
6 commission, the commission may not discount premium
7 payment rates in an amount that is more than the amount
8 necessary to meet federal budget neutrality
9 requirements for projected fee-for-service costs
10 unless:

11 (1) a historical review of managed care
12 financial results among managed care organizations in
13 the service area served by the organization
14 demonstrates that additional savings are warranted;

15 (2) a review of Medicaid fee-for-service
16 delivery in the service area served by the
17 organization has historically shown a significant
18 overutilization by recipients of certain services
19 covered by the premium payment rates in comparison to
20 utilization patterns throughout the rest of the state;
21 or

22 (3) a review of Medicaid fee-for-service
23 delivery in the service area served by the
24 organization has historically shown an above-market
25 cost for services for which there is substantial
26 evidence that Medicaid managed care delivery will
27 reduce the cost of those services.

28 (d) Subsection (b) applies only to a managed
29 care organization with respect to Medicaid managed
30 care pilot programs, Medicaid behavioral health pilot
31 programs, and Medicaid Star + Plus pilot programs
32 implemented in a health care service region after June
33 1, 1999.

34 Revisor's Note

35 Section 533.013(b), Government Code, refers to a
36 managed care organization that "is licensed" under
37 Chapter 843, Insurance Code. The revised law
38 substitutes "holds a certificate of authority" for the
39 quoted language for the reason stated in Revisor's Note
40 (2) to Section 540.0206 of this chapter.

41 Revised Law

42 Sec. 540.0353. USE OF ENCOUNTER DATA IN DETERMINING PREMIUM
43 PAYMENT RATES AND OTHER PAYMENT AMOUNTS. (a) In determining
44 premium payment rates and other amounts paid to managed care
45 organizations under a managed care plan, the commission may not
46 base or derive the rates or amounts on or from encounter data, or
47 incorporate in the determination an analysis of encounter data,
48 unless a certifier of encounter data certifies that:

49 (1) the encounter data for the most recent state
50 fiscal year is complete, accurate, and reliable; and

1 (2) there is no statistically significant variability
2 in the encounter data attributable to incompleteness, inaccuracy,
3 or another deficiency as compared to equivalent data for similar
4 populations and when evaluated against professionally accepted
5 standards.

6 (b) In determining whether data is equivalent data for
7 similar populations under Subsection (a)(2), a certifier of
8 encounter data shall, at a minimum, consider:

9 (1) the regional variation in recipient utilization
10 patterns and health care service costs;

11 (2) the range and type of health care services premium
12 payment rates are to cover;

13 (3) the number of managed care plans in the region; and

14 (4) the current number of recipients in each region,
15 including the number for each recipient category. (Gov. Code, Sec.
16 533.0131.)

17 Source Law

18 Sec. 533.0131. USE OF ENCOUNTER DATA IN
19 DETERMINING PREMIUM PAYMENT RATES. (a) In
20 determining premium payment rates and other amounts
21 paid to managed care organizations under a managed
22 care plan, the commission may not base or derive the
23 rates or amounts on or from encounter data, or
24 incorporate in the determination an analysis of
25 encounter data, unless a certifier of encounter data
26 certifies that:

27 (1) the encounter data for the most recent
28 state fiscal year is complete, accurate, and reliable;
29 and

30 (2) there is no statistically significant
31 variability in the encounter data attributable to
32 incompleteness, inaccuracy, or another deficiency as
33 compared to equivalent data for similar populations
34 and when evaluated against professionally accepted
35 standards.

36 (b) For purposes of determining whether data is
37 equivalent data for similar populations under
38 Subsection (a)(2), a certifier of encounter data
39 shall, at a minimum, consider:

40 (1) the regional variation in utilization
41 patterns of recipients and costs of health care
42 services;

43 (2) the range and type of health care
44 services to be covered by premium payment rates;

45 (3) the number of managed care plans in the
46 region; and

47 (4) the current number of recipients in
48 each region, including the number for each category of
49 recipient.

1 SUBCHAPTER I. ENCOUNTER DATA

2 Revised Law

3 Sec. 540.0401. PROVIDER REPORTING OF ENCOUNTER DATA. The
4 commission shall collaborate with Medicaid managed care
5 organizations and health care providers in the organizations'
6 provider networks to develop incentives and mechanisms to encourage
7 providers to report complete and accurate encounter data to the
8 organizations in a timely manner. (Gov. Code, Sec. 533.016.)

9 Source Law

10 Sec. 533.016. PROVIDER REPORTING OF ENCOUNTER
11 DATA. The commission shall collaborate with managed
12 care organizations that contract with the commission
13 and health care providers under the organizations'
14 provider networks to develop incentives and mechanisms
15 to encourage providers to report complete and accurate
16 encounter data to managed care organizations in a
17 timely manner.

18 Revised Law

19 Sec. 540.0402. CERTIFIER OF ENCOUNTER DATA QUALIFICATIONS.

20 (a) The state Medicaid director shall appoint a person as the
21 certifier of encounter data.

22 (b) The certifier of encounter data must have:

23 (1) demonstrated expertise in estimating premium
24 payment rates paid to a managed care organization under a managed
25 care plan; and

26 (2) access to actuarial expertise, including
27 expertise in estimating premium payment rates paid to a managed
28 care organization under a managed care plan.

29 (c) A person may not be appointed as the certifier of
30 encounter data if the person participated with the commission in
31 developing premium payment rates for managed care organizations
32 under managed care plans in this state during the three-year period
33 before the date the certifier is appointed. (Gov. Code, Sec.
34 533.017.)

35 Source Law

36 Sec. 533.017. QUALIFICATIONS OF CERTIFIER OF
37 ENCOUNTER DATA. (a) The person acting as the state
38 Medicaid director shall appoint a person as the
39 certifier of encounter data.

1 (b) The certifier of encounter data must have:
2 (1) demonstrated expertise in estimating
3 premium payment rates paid to a managed care
4 organization under a managed care plan; and

5 (2) access to actuarial expertise,
6 including expertise in estimating premium payment
7 rates paid to a managed care organization under a
8 managed care plan.

9 (c) A person may not be appointed under this
10 section as the certifier of encounter data if the
11 person participated with the commission in developing
12 premium payment rates for managed care organizations
13 under managed care plans in this state during the
14 three-year period before the date the certifier is
15 appointed.

16 Revised Law

17 Sec. 540.0403. ENCOUNTER DATA CERTIFICATION. (a) The
18 certifier of encounter data shall certify the completeness,
19 accuracy, and reliability of encounter data for each state fiscal
20 year.

21 (b) The commission shall make available to the certifier of
22 encounter data all records and data the certifier considers
23 appropriate for evaluating whether to certify the encounter data.
24 The commission shall provide to the certifier selected resources
25 and assistance in obtaining, compiling, and interpreting the
26 records and data. (Gov. Code, Sec. 533.018.)

27 Source Law

28 Sec. 533.018. CERTIFICATION OF ENCOUNTER DATA.
29 (a) The certifier of encounter data shall certify the
30 completeness, accuracy, and reliability of encounter
31 data for each state fiscal year.

32 (b) The commission shall make available to the
33 certifier all records and data the certifier considers
34 appropriate for evaluating whether to certify the
35 encounter data. The commission shall provide to the
36 certifier selected resources and assistance in
37 obtaining, compiling, and interpreting the records and
38 data.

39 SUBCHAPTER J. MANAGED CARE PLAN REQUIREMENTS

40 Revised Law

41 Sec. 540.0451. MEDICAID MANAGED CARE PLAN ACCREDITATION.

42 (a) A Medicaid managed care plan must be accredited by a nationally
43 recognized accreditation organization. The commission may:

44 (1) require all Medicaid managed care plans to be
45 accredited by the same organization; or

46 (2) allow for accreditation by different

1 organizations.

2 (b) The commission may use the data, scoring, and other
3 information provided to or received from an accreditation
4 organization in the commission's contract oversight process. (Gov.
5 Code, Sec. 533.0031.)

6 Source Law

7 Sec. 533.0031. MEDICAID MANAGED CARE PLAN
8 ACCREDITATION. (a) A managed care plan offered by a
9 Medicaid managed care organization must be accredited
10 by a nationally recognized accreditation
11 organization. The commission may choose whether to
12 require all managed care plans offered by Medicaid
13 managed care organizations to be accredited by the
14 same organization or to allow for accreditation by
15 different organizations.

16 (b) The commission may use the data, scoring,
17 and other information provided to or received from an
18 accreditation organization in the commission's
19 contract oversight processes.

20 Revised Law

21 Sec. 540.0452. MEDICAL DIRECTOR QUALIFICATIONS. An
22 individual who serves as a medical director for a managed care plan
23 must be a physician licensed to practice medicine in this state
24 under Subtitle B, Title 3, Occupations Code. (Gov. Code, Sec.
25 533.0073.)

26 Source Law

27 Sec. 533.0073. MEDICAL DIRECTOR
28 QUALIFICATIONS. A person who serves as a medical
29 director for a managed care plan must be a physician
30 licensed to practice medicine in this state under
31 Subtitle B, Title 3, Occupations Code.

32 Revisor's Note

33 Section 533.0073, Government Code, requires a
34 "person" who serves as a medical director for a managed
35 care plan to be a physician. Throughout this chapter,
36 the revised law substitutes "individual" for "person"
37 for clarity and consistency where the context makes
38 clear that the referenced person is a natural person
39 and not an entity described by the definition of
40 "person" provided by Section 311.005(2), Government
41 Code (Code Construction Act), which applies to this
42 code.

1 SUBCHAPTER K. MEDICAID MANAGED CARE PLAN ENROLLMENT AND
2 DISENROLLMENT

3 Revised Law

4 Sec. 540.0501. RECIPIENT ENROLLMENT IN AND DISENROLLMENT
5 FROM MEDICAID MANAGED CARE PLAN. The commission shall:

6 (1) encourage recipients to choose appropriate
7 Medicaid managed care plans and primary health care providers by:

8 (A) providing initial information to recipients
9 and providers in a region about the need for recipients to choose
10 plans and providers not later than the 90th day before the date a
11 Medicaid managed care organization plans to begin providing health
12 care services to recipients in that region through managed care;

13 (B) providing follow-up information before
14 assignment of plans and providers and after assignment, if
15 necessary, to recipients who delay in choosing plans and providers;
16 and

17 (C) allowing plans and providers to provide
18 information to recipients or engage in marketing activities under
19 marketing guidelines the commission establishes under Section
20 540.0055(a) after the commission approves the information or
21 activities;

22 (2) in assigning plans and providers to recipients who
23 fail to choose plans and providers, consider:

24 (A) the importance of maintaining existing
25 provider-patient and physician-patient relationships, including
26 relationships with specialists, public health clinics, and
27 community health centers;

28 (B) to the extent possible, the need to assign
29 family members to the same providers and plans; and

30 (C) geographic convenience of plans and
31 providers for recipients;

32 (3) retain responsibility for enrolling recipients in
33 and disenrolling recipients from plans, except that the commission
34 may delegate the responsibility to an independent contractor who

1 receives no form of payment from, and has no financial ties to, any
2 managed care organization;

3 (4) develop and implement an expedited process for
4 determining eligibility for and enrolling pregnant women and
5 newborn infants in plans; and

6 (5) ensure immediate access to prenatal services and
7 newborn care for pregnant women and newborn infants enrolled in
8 plans, including ensuring that a pregnant woman may obtain an
9 appointment with an obstetrical care provider for an initial
10 maternity evaluation not later than the 30th day after the date the
11 woman applies for Medicaid. (Gov. Code, Sec. 533.0075.)

12 Source Law

13 Sec. 533.0075. RECIPIENT ENROLLMENT. The
14 commission shall:

15 (1) encourage recipients to choose
16 appropriate managed care plans and primary health care
17 providers by:

18 (A) providing initial information to
19 recipients and providers in a region about the need for
20 recipients to choose plans and providers not later
21 than the 90th day before the date on which a managed
22 care organization plans to begin to provide health
23 care services to recipients in that region through
24 managed care;

25 (B) providing follow-up information
26 before assignment of plans and providers and after
27 assignment, if necessary, to recipients who delay in
28 choosing plans and providers; and

29 (C) allowing plans and providers to
30 provide information to recipients or engage in
31 marketing activities under marketing guidelines
32 established by the commission under Section 533.008
33 after the commission approves the information or
34 activities;

35 (2) consider the following factors in
36 assigning managed care plans and primary health care
37 providers to recipients who fail to choose plans and
38 providers:

39 (A) the importance of maintaining
40 existing provider-patient and physician-patient
41 relationships, including relationships with
42 specialists, public health clinics, and community
43 health centers;

44 (B) to the extent possible, the need
45 to assign family members to the same providers and
46 plans; and

47 (C) geographic convenience of plans
48 and providers for recipients;

49 (3) retain responsibility for enrollment
50 and disenrollment of recipients in managed care plans,
51 except that the commission may delegate the
52 responsibility to an independent contractor who
53 receives no form of payment from, and has no financial
54 ties to, any managed care organization;

55 (4) develop and implement an expedited

1 process for determining eligibility for and enrolling
2 pregnant women and newborn infants in managed care
3 plans; and

4 (5) ensure immediate access to prenatal
5 services and newborn care for pregnant women and
6 newborn infants enrolled in managed care plans,
7 including ensuring that a pregnant woman may obtain an
8 appointment with an obstetrical care provider for an
9 initial maternity evaluation not later than the 30th
10 day after the date the woman applies for Medicaid.

11 Revisor's Note

12 Section 533.0075(1)(C), Government Code, refers
13 to marketing guidelines the Health and Human Services
14 Commission establishes under Section 533.008,
15 Government Code. The relevant portion of Section
16 533.008 requiring the commission to establish those
17 guidelines is revised in this chapter as Section
18 540.0055(a), and the revised law is drafted
19 accordingly.

20 Revised Law

21 Sec. 540.0502. AUTOMATIC ENROLLMENT IN MEDICAID MANAGED
22 CARE PLAN. (a) If the commission determines that it is feasible
23 and notwithstanding any other law, the commission may implement an
24 automatic enrollment process under which an applicant determined
25 eligible for Medicaid is automatically enrolled in a Medicaid
26 managed care plan the applicant chooses.

27 (b) The commission may elect to implement the automatic
28 enrollment process for certain recipient populations. (Gov. Code,
29 Sec. 533.0025(h).)

30 Source Law

31 (h) If the commission determines that it is
32 feasible, the commission may, notwithstanding any
33 other law, implement an automatic enrollment process
34 under which applicants determined eligible for
35 Medicaid benefits are automatically enrolled in a
36 Medicaid managed care plan chosen by the applicant.
37 The commission may elect to implement the automatic
38 enrollment process as to certain populations of
39 recipients.

40 Revised Law

41 Sec. 540.0503. ENROLLMENT OF CERTAIN RECIPIENTS IN SAME
42 MEDICAID MANAGED CARE PLAN. The commission shall ensure that all
43 recipients who are children and who reside in the same household

1 may, at the family's election, be enrolled in the same Medicaid
2 managed care plan. (Gov. Code, Sec. 533.0027.)

3 Source Law

4 Sec. 533.0027. PROCEDURES TO ENSURE CERTAIN
5 RECIPIENTS ARE ENROLLED IN SAME MANAGED CARE PLAN. The
6 commission shall ensure that all recipients who are
7 children and who reside in the same household may, at
8 the family's election, be enrolled in the same managed
9 care plan.

10 Revised Law

11 Sec. 540.0504. QUALITY-BASED ENROLLMENT INCENTIVE PROGRAM
12 FOR MEDICAID MANAGED CARE ORGANIZATIONS. The commission shall
13 create an incentive program that automatically enrolls in a
14 Medicaid managed care plan a greater percentage of recipients who
15 did not actively choose a plan, based on:

16 (1) the quality of care provided through the Medicaid
17 managed care organization offering the plan;

18 (2) the organization's ability to efficiently and
19 effectively provide services, considering the acuity of
20 populations the organization primarily serves; and

21 (3) the organization's performance with respect to
22 exceeding or failing to achieve appropriate outcome and process
23 measures the commission develops, including measures based on
24 potentially preventable events. (Gov. Code, Sec. 533.00511(b).)

25 Source Law

26 (b) The commission shall create an incentive
27 program that automatically enrolls a greater
28 percentage of recipients who did not actively choose
29 their managed care plan in a managed care plan, based
30 on:

31 (1) the quality of care provided through
32 the managed care organization offering that managed
33 care plan;

34 (2) the organization's ability to
35 efficiently and effectively provide services, taking
36 into consideration the acuity of populations primarily
37 served by the organization; and

38 (3) the organization's performance with
39 respect to exceeding, or failing to achieve,
40 appropriate outcome and process measures developed by
41 the commission, including measures based on
42 potentially preventable events.

43 Revised Law

44 Sec. 540.0505. LIMITATIONS ON RECIPIENT DISENROLLMENT FROM

1 MEDICAID MANAGED CARE PLAN. (a) Except as provided by Subsections
2 (b) and (c) and to the extent permitted by federal law, a recipient
3 enrolled in a Medicaid managed care plan may not disenroll from that
4 plan and enroll in another Medicaid managed care plan during the
5 12-month period after the date the recipient initially enrolls in a
6 plan.

7 (b) At any time before the 91st day after the date of a
8 recipient's initial enrollment in a Medicaid managed care plan, the
9 recipient may disenroll from that plan for any reason and enroll in
10 another Medicaid managed care plan.

11 (c) The commission shall allow a recipient who is enrolled
12 in a Medicaid managed care plan to disenroll from that plan and
13 enroll in another Medicaid managed care plan:

14 (1) at any time for cause in accordance with federal
15 law; and

16 (2) once for any reason after the periods described by
17 Subsections (a) and (b). (Gov. Code, Sec. 533.0076.)

18 Source Law

19 Sec. 533.0076. LIMITATIONS ON RECIPIENT
20 DISENROLLMENT. (a) Except as provided by Subsections
21 (b) and (c), and to the extent permitted by federal
22 law, a recipient enrolled in a managed care plan under
23 this chapter may not disenroll from that plan and
24 enroll in another managed care plan during the
25 12-month period after the date the recipient initially
26 enrolls in a plan.

27 (b) At any time before the 91st day after the
28 date of a recipient's initial enrollment in a managed
29 care plan under this chapter, the recipient may
30 disenroll in that plan for any reason and enroll in
31 another managed care plan under this chapter.

32 (c) The commission shall allow a recipient who
33 is enrolled in a managed care plan under this chapter
34 to disenroll from that plan and enroll in another
35 managed care plan:

36 (1) at any time for cause in accordance
37 with federal law; and

38 (2) once for any reason after the periods
39 described by Subsections (a) and (b).

40 SUBCHAPTER L. CONTINUITY OF CARE AND COORDINATION OF BENEFITS

41 Revised Law

42 Sec. 540.0551. GUIDANCE REGARDING CONTINUATION OF SERVICES
43 UNDER CERTAIN CIRCUMSTANCES. The commission shall provide guidance
44 and additional education to Medicaid managed care organizations

1 regarding federal law requirements to continue providing services
2 during an internal appeal, a Medicaid fair hearing, or any other
3 review. (Gov. Code, Sec. 533.005(g).)

4 Source Law

5 (g) The commission shall provide guidance and
6 additional education to managed care organizations
7 with which the commission enters into contracts
8 described by Subsection (a) regarding requirements
9 under federal law to continue to provide services
10 during an internal appeal, a Medicaid fair hearing, or
11 any other review.

12 Revisor's Note

13 Section 533.005(g), Government Code, refers to
14 "managed care organizations with which the commission
15 enters into contracts described by Subsection (a)" of
16 Section 533.005, Government Code. Section 533.005(a)
17 describes a contract between a managed care
18 organization and the commission for the organization
19 to provide health care services to Medicaid
20 recipients. The revised law substitutes "Medicaid
21 managed care organizations" for the quoted language
22 for the reason stated in the revisor's note to Section
23 540.0053.

24 Revised Law

25 Sec. 540.0552. COORDINATION OF BENEFITS; CONTINUITY OF
26 SPECIALTY CARE FOR CERTAIN RECIPIENTS. (a) In this section,
27 "Medicaid wrap-around benefit" means a Medicaid-covered service,
28 including a pharmacy or medical benefit, that is provided to a
29 recipient who has primary health benefit plan coverage in addition
30 to Medicaid coverage when:

31 (1) the recipient has exceeded the primary health
32 benefit plan coverage limit; or

33 (2) the service is not covered by the primary health
34 benefit plan issuer.

35 (b) The commission, in coordination with Medicaid managed
36 care organizations, shall develop and adopt a clear policy for a
37 Medicaid managed care organization to ensure the coordination and

1 timely delivery of Medicaid wrap-around benefits for recipients who
2 have primary health benefit plan coverage in addition to Medicaid
3 coverage. In developing the policy, the commission shall consider
4 requiring a Medicaid managed care organization to allow,
5 notwithstanding Sections _____ [[[Section 531.073]]], 540.0273,
6 and 540.0280 or any other law, a recipient using a prescription drug
7 for which the recipient's primary health benefit plan issuer
8 previously provided coverage to continue receiving the
9 prescription drug without requiring additional prior
10 authorization.

11 (c) If the commission determines that a recipient's primary
12 health benefit plan issuer should have been the primary payor of a
13 claim, the Medicaid managed care organization that paid the claim
14 shall:

15 (1) work with the commission on the recovery process;
16 and

17 (2) make every attempt to reduce health care provider
18 and recipient abrasion.

19 (d) The executive commissioner may seek a waiver from the
20 federal government as needed to:

21 (1) address federal policies related to coordination
22 of benefits and third-party liability; and

23 (2) maximize federal financial participation for
24 recipients who have primary health benefit plan coverage in
25 addition to Medicaid coverage.

26 (e) The commission may include in the Medicaid managed care
27 eligibility files an indication of whether a recipient has primary
28 health benefit plan coverage or is enrolled in a group health
29 benefit plan for which the commission provides premium assistance
30 under the health insurance premium payment program. For a recipient
31 with that coverage or for whom that premium assistance is provided,
32 the files may include the following up-to-date, accurate
33 information related to primary health benefit plan coverage to the
34 extent the information is available to the commission:

1 (1) the primary health benefit plan issuer's name and
2 address;

3 (2) the recipient's policy number;

4 (3) the primary health benefit plan coverage start and
5 end dates; and

6 (4) the primary health benefit plan coverage benefits,
7 limits, copayment, and coinsurance information.

8 (f) To the extent allowed by federal law, the commission
9 shall maintain processes and policies to allow a health care
10 provider who is primarily providing services to a recipient through
11 primary health benefit plan coverage to receive Medicaid
12 reimbursement for services ordered, referred, or prescribed,
13 regardless of whether the provider is enrolled as a Medicaid
14 provider. The commission shall allow a provider who is not enrolled
15 as a Medicaid provider to order, refer, or prescribe services to a
16 recipient based on the provider's national provider identifier
17 number and may not require an additional state provider identifier
18 number to receive reimbursement for the services. The commission
19 may seek a waiver of Medicaid provider enrollment requirements for
20 providers of recipients with primary health benefit plan coverage
21 to implement this subsection.

22 (g) The commission shall develop a clear and easy process,
23 to be implemented through a contract, that allows a recipient with
24 complex medical needs who has established a relationship with a
25 specialty provider to continue receiving care from that provider,
26 regardless of whether the recipient has primary health benefit plan
27 coverage in addition to Medicaid coverage.

28 (h) If a recipient who has complex medical needs wants to
29 continue to receive care from a specialty provider that is not in
30 the provider network of the Medicaid managed care organization
31 offering the Medicaid managed care plan in which the recipient is
32 enrolled, the organization shall develop a simple, timely, and
33 efficient process to, and shall make a good-faith effort to,
34 negotiate a single-case agreement with the specialty provider.

1 Until the organization and the specialty provider enter into the
2 single-case agreement, the specialty provider shall be reimbursed
3 in accordance with the applicable reimbursement methodology
4 specified in commission rules, including 1 T.A.C. Section 353.4.

5 (i) A single-case agreement entered into under this section
6 is not considered accessing an out-of-network provider for the
7 purposes of Medicaid managed care organization network adequacy
8 requirements. (Gov. Code, Sec. 533.038.)

9 Source Law

10 Sec. 533.038. COORDINATION OF BENEFITS;
11 CONTINUITY OF SPECIALTY CARE FOR CERTAIN RECIPIENTS.

12 (a) In this section, "Medicaid wrap-around benefit"
13 means a Medicaid-covered service, including a pharmacy
14 or medical benefit, that is provided to a recipient
15 with both Medicaid and primary health benefit plan
16 coverage when the recipient has exceeded the primary
17 health benefit plan coverage limit or when the service
18 is not covered by the primary health benefit plan
19 issuer.

20 (b) The commission, in coordination with
21 Medicaid managed care organizations and in
22 consultation with the STAR Kids Managed Care Advisory
23 Committee described by Section 533.00254, shall
24 develop and adopt a clear policy for a Medicaid managed
25 care organization to ensure the coordination and
26 timely delivery of Medicaid wrap-around benefits for
27 recipients with both primary health benefit plan
28 coverage and Medicaid coverage. In developing the
29 policy, the commission shall consider requiring a
30 Medicaid managed care organization to allow,
31 notwithstanding Sections 531.073 and 533.005(a)(23)
32 or any other law, a recipient using a prescription drug
33 for which the recipient's primary health benefit plan
34 issuer previously provided coverage to continue
35 receiving the prescription drug without requiring
36 additional prior authorization.

37 (c) If the commission determines that a
38 recipient's primary health benefit plan issuer should
39 have been the primary payor of a claim, the Medicaid
40 managed care organization that paid the claim shall
41 work with the commission on the recovery process and
42 make every attempt to reduce health care provider and
43 recipient abrasion.

44 (d) The executive commissioner may seek a waiver
45 from the federal government as needed to:

46 (1) address federal policies related to
47 coordination of benefits and third-party liability;
48 and

49 (2) maximize federal financial
50 participation for recipients with both primary health
51 benefit plan coverage and Medicaid coverage.

52 (e) The commission may include in the Medicaid
53 managed care eligibility files an indication of
54 whether a recipient has primary health benefit plan
55 coverage or is enrolled in a group health benefit plan
56 for which the commission provides premium assistance
57 under the health insurance premium payment program.
58 For recipients with that coverage or for whom that

1 premium assistance is provided, the files may include
2 the following up-to-date, accurate information
3 related to primary health benefit plan coverage to the
4 extent the information is available to the commission:

5 (1) the health benefit plan issuer's name
6 and address and the recipient's policy number;

7 (2) the primary health benefit plan
8 coverage start and end dates; and

9 (3) the primary health benefit plan
10 coverage benefits, limits, copayment, and coinsurance
11 information.

12 (f) To the extent allowed by federal law, the
13 commission shall maintain processes and policies to
14 allow a health care provider who is primarily
15 providing services to a recipient through primary
16 health benefit plan coverage to receive Medicaid
17 reimbursement for services ordered, referred, or
18 prescribed, regardless of whether the provider is
19 enrolled as a Medicaid provider. The commission shall
20 allow a provider who is not enrolled as a Medicaid
21 provider to order, refer, or prescribe services to a
22 recipient based on the provider's national provider
23 identifier number and may not require an additional
24 state provider identifier number to receive
25 reimbursement for the services. The commission may
26 seek a waiver of Medicaid provider enrollment
27 requirements for providers of recipients with primary
28 health benefit plan coverage to implement this
29 subsection.

30 (g) The commission shall develop a clear and
31 easy process, to be implemented through a contract,
32 that allows a recipient with complex medical needs who
33 has established a relationship with a specialty
34 provider to continue receiving care from that
35 provider, regardless of whether the recipient has
36 primary health benefit plan coverage in addition to
37 Medicaid coverage.

38 (h) If a recipient who has complex medical needs
39 wants to continue to receive care from a specialty
40 provider that is not in the provider network of the
41 Medicaid managed care organization offering the
42 managed care plan in which the recipient is enrolled,
43 the managed care organization shall develop a simple,
44 timely, and efficient process to and shall make a
45 good-faith effort to, negotiate a single-case
46 agreement with the specialty provider. Until the
47 Medicaid managed care organization and the specialty
48 provider enter into the single-case agreement, the
49 specialty provider shall be reimbursed in accordance
50 with the applicable reimbursement methodology
51 specified in commission rule, including 1 T.A.C.
52 Section 353.4.

53 (i) A single-case agreement entered into under
54 this section is not considered accessing an
55 out-of-network provider for the purposes of Medicaid
56 managed care organization network adequacy
57 requirements.

58 Revisor's Note

59 (1) Section 533.038(b), Government Code,
60 requires the Health and Human Services Commission to
61 consult with the "STAR Kids Managed Care Advisory
62 Committee described by Section 533.00254," Government

1 Code. That advisory committee will be abolished, and
2 Section 533.00254 expires, December 31, 2023, in
3 accordance with Section 533.00254(b). Because the
4 effective date of the revised law is later than the
5 date the advisory committee is to be abolished and the
6 cited section expires, the revised law omits the
7 quoted language as obsolete.

8 (2) Section 533.038(b), Government Code, refers
9 to continuous receipt of certain prescription drugs
10 without additional prior authorization,
11 notwithstanding Section 533.005(a)(23), Government
12 Code. The provisions of Section 533.005(a)(23) that
13 require Medicaid managed care organizations to
14 maintain an outpatient pharmacy benefit plan that
15 includes or allows for certain prior authorization
16 requirements are revised in this chapter as Sections
17 540.0273 and 540.0280, and the revised law is drafted
18 accordingly.

19 SUBCHAPTER M. PROVIDER NETWORK ADEQUACY

20 Revised Law

21 Sec. 540.0601. MONITORING OF PROVIDER NETWORKS. The
22 commission shall establish and implement a process for the direct
23 monitoring of a Medicaid managed care organization's provider
24 network and providers in the network. The process:

25 (1) must be used to ensure compliance with contractual
26 obligations related to:

27 (A) the number of providers accepting new
28 patients under the Medicaid managed care program; and

29 (B) the length of time a recipient must wait
30 between scheduling an appointment with a provider and receiving
31 treatment from the provider;

32 (2) may use reasonable methods to ensure compliance
33 with contractual obligations, including telephone calls made at
34 random times without notice to assess the availability of providers

1 and services to new and existing recipients; and

2 (3) may be implemented directly by the commission or
3 through a contractor. (Gov. Code, Sec. 533.007(1).)

4 Source Law

5 (1) The commission shall establish and
6 implement a process for the direct monitoring of a
7 managed care organization's provider network and
8 providers in the network. The process:

9 (1) must be used to ensure compliance with
10 contractual obligations related to:

11 (A) the number of providers accepting
12 new patients under the Medicaid managed care program;
13 and

14 (B) the length of time a recipient
15 must wait between scheduling an appointment with a
16 provider and receiving treatment from the provider;

17 (2) may use reasonable methods to ensure
18 compliance with contractual obligations, including
19 telephone calls made at random times without notice to
20 assess the availability of providers and services to
21 new and existing recipients; and

22 (3) may be implemented directly by the
23 commission or through a contractor.

24 Revised Law

25 Sec. 540.0602. REPORT ON OUT-OF-NETWORK PROVIDER SERVICES.

26 To ensure appropriate access to an adequate provider network, each
27 Medicaid managed care organization providing health care services
28 to recipients in a health care service region shall submit to the
29 commission, in the format and manner the commission prescribes, a
30 report detailing the number, type, and scope of services
31 out-of-network providers provide to recipients enrolled in a
32 Medicaid managed care plan the organization provides. (Gov. Code,
33 Sec. 533.007(g) (part).)

34 Source Law

35 (g) To ensure appropriate access to an adequate
36 provider network, each managed care organization that
37 contracts with the commission to provide health care
38 services to recipients in a health care service region
39 shall submit to the commission, in the format and
40 manner prescribed by the commission, a report
41 detailing the number, type, and scope of services
42 provided by out-of-network providers to recipients
43 enrolled in a managed care plan provided by the managed
44 care organization. . . .

45 Revised Law

46 Sec. 540.0603. REPORT ON COMMISSION INVESTIGATION OF
47 PROVIDER COMPLAINT. Not later than the 60th day after the date a

1 provider files a complaint with the commission regarding
2 reimbursement for or overuse of out-of-network providers by a
3 Medicaid managed care organization, the commission shall provide to
4 the provider a report regarding the conclusions of the commission's
5 investigation. The report must include:

6 (1) a description of any corrective action required of
7 the organization that was the subject of the complaint; and

8 (2) if applicable, a conclusion regarding the amount
9 of reimbursement owed to an out-of-network provider. (Gov. Code,
10 Sec. 533.007(i).)

11 Source Law

12 (i) Not later than the 60th day after the date a
13 provider files a complaint with the commission
14 regarding reimbursement for or overuse of
15 out-of-network providers by a managed care
16 organization, the commission shall provide to the
17 provider a report regarding the conclusions of the
18 commission's investigation. The report must include:

19 (1) a description of the corrective
20 action, if any, required of the managed care
21 organization that was the subject of the complaint;
22 and

23 (2) if applicable, a conclusion regarding
24 the amount of reimbursement owed to an out-of-network
25 provider.

26 Revised Law

27 Sec. 540.0604. ADDITIONAL REIMBURSEMENT FOLLOWING PROVIDER
28 COMPLAINT. (a) If, after an investigation, the commission
29 determines that a Medicaid managed care organization owes
30 additional reimbursement to a provider, the organization shall, not
31 later than the 90th day after the date the provider filed the
32 complaint, pay the additional reimbursement or provide to the
33 provider a reimbursement payment plan under which the organization
34 must pay the entire amount of the additional reimbursement not
35 later than the 120th day after the date the provider filed the
36 complaint.

37 (b) The commission may require a Medicaid managed care
38 organization to pay interest on any amount of the additional
39 reimbursement that is not paid on or before the 90th day after the
40 date the provider to whom the amount is owed filed the complaint.

1 If the commission requires the organization to pay interest,
2 interest accrues at a rate of 18 percent simple interest per year on
3 the unpaid amount beginning on the 90th day after the date the
4 provider to whom the amount is owed filed the complaint and accrues
5 until the date the organization pays the entire reimbursement
6 amount. (Gov. Code, Sec. 533.007(j).)

7 Source Law

8 (j) If, after an investigation, the commission
9 determines that additional reimbursement is owed to a
10 provider, the managed care organization shall, not
11 later than the 90th day after the date the provider
12 filed the complaint, pay the additional reimbursement
13 or provide to the provider a reimbursement payment
14 plan under which the managed care organization must
15 pay the entire amount of the additional reimbursement
16 not later than the 120th day after the date the
17 provider filed the complaint. If the managed care
18 organization does not pay the entire amount of the
19 additional reimbursement on or before the 90th day
20 after the date the provider filed the complaint, the
21 commission may require the managed care organization
22 to pay interest on the unpaid amount. If required by
23 the commission, interest accrues at a rate of 18
24 percent simple interest per year on the unpaid amount
25 from the 90th day after the date the provider filed the
26 complaint until the date the entire amount of the
27 additional reimbursement is paid.

28 Revised Law

29 Sec. 540.0605. CORRECTIVE ACTION PLAN FOR INADEQUATE
30 NETWORK AND PROVIDER REIMBURSEMENT. (a) The commission shall
31 initiate a corrective action plan requiring a Medicaid managed care
32 organization to maintain an adequate provider network, provide
33 reimbursement to support that network, and educate recipients
34 enrolled in Medicaid managed care plans provided by the
35 organization regarding the proper use of the plan's provider
36 network, if:

37 (1) as the commission determines, the organization
38 exceeds maximum limits the commission established for
39 out-of-network access to health care services; or

40 (2) based on the commission's investigation of a
41 provider complaint regarding reimbursement, the commission
42 determines that the organization did not reimburse an
43 out-of-network provider based on a reasonable reimbursement

1 methodology.

2 (b) The corrective action plan required by Subsection (a)
3 must include at least one of the following elements:

4 (1) a requirement that reimbursements the Medicaid
5 managed care organization pays to out-of-network providers for a
6 health care service provided to a recipient enrolled in a Medicaid
7 managed care plan provided by the organization equal the allowable
8 rate for the service, as determined under Sections 32.028 and
9 32.0281, Human Resources Code, for all health care services
10 provided during the period the organization:

11 (A) is not in compliance with the utilization
12 benchmarks the commission determines; or

13 (B) is not reimbursing out-of-network providers
14 based on a reasonable methodology, as the commission determines;

15 (2) an immediate freeze on the enrollment of
16 additional recipients in a Medicaid managed care plan the
17 organization provides that continues until the commission
18 determines that the provider network under the plan can adequately
19 meet the needs of additional recipients; and

20 (3) other actions the commission determines are
21 necessary to ensure that recipients enrolled in a Medicaid managed
22 care plan the organization provides have access to appropriate
23 health care services and that providers are properly reimbursed for
24 providing medically necessary health care services to those
25 recipients. (Gov. Code, Secs. 533.007(g) (part), (h).)

26 Source Law

27 (g) . . . If, as determined by the commission,
28 a managed care organization exceeds maximum limits
29 established by the commission for out-of-network
30 access to health care services, or if, based on an
31 investigation by the commission of a provider
32 complaint regarding reimbursement, the commission
33 determines that a managed care organization did not
34 reimburse an out-of-network provider based on a
35 reasonable reimbursement methodology, the commission
36 shall initiate a corrective action plan requiring the
37 managed care organization to maintain an adequate
38 provider network, provide reimbursement to support
39 that network, and educate recipients enrolled in
40 managed care plans provided by the managed care
41 organization regarding the proper use of the provider

1 network under the plan.

2 (h) The corrective action plan required by
3 Subsection (g) must include at least one of the
4 following elements:

5 (1) a requirement that reimbursements paid
6 by the managed care organization to out-of-network
7 providers for a health care service provided to a
8 recipient enrolled in a managed care plan provided by
9 the managed care organization equal the allowable rate
10 for the service, as determined under Sections 32.028
11 and 32.0281, Human Resources Code, for all health care
12 services provided during the period:

13 (A) the managed care organization is
14 not in compliance with the utilization benchmarks
15 determined by the commission; or

16 (B) the managed care organization is
17 not reimbursing out-of-network providers based on a
18 reasonable methodology, as determined by the
19 commission;

20 (2) an immediate freeze on the enrollment
21 of additional recipients in a managed care plan
22 provided by the managed care organization, to continue
23 until the commission determines that the provider
24 network under the managed care plan can adequately
25 meet the needs of additional recipients; and

26 (3) other actions the commission
27 determines are necessary to ensure that recipients
28 enrolled in a managed care plan provided by the managed
29 care organization have access to appropriate health
30 care services and that providers are properly
31 reimbursed for providing medically necessary health
32 care services to those recipients.

33 Revised Law

34 Sec. 540.0606. REMEDIES FOR NONCOMPLIANCE WITH CORRECTIVE
35 ACTION PLAN. The commission shall pursue any appropriate remedy
36 authorized in the contract between the Medicaid managed care
37 organization and the commission if the organization fails to comply
38 with a corrective action plan under Section 540.0605(a). (Gov.
39 Code, Sec. 533.007(k).)

40 Source Law

41 (k) The commission shall pursue any appropriate
42 remedy authorized in the contract between the managed
43 care organization and the commission if the managed
44 care organization fails to comply with a corrective
45 action plan under Subsection (g).

46 Revisor's Note

47 Section 533.007(k), Government Code, refers to a
48 corrective action plan under Section 533.007(g),
49 Government Code. The relevant portion of Section
50 533.007(g) is revised in this chapter as Section
51 540.0605(a), and the revised law is drafted
52 accordingly.

1 SUBCHAPTER N. PROVIDERS

2 Revised Law

3 Sec. 540.0651. INCLUSION OF CERTAIN PROVIDERS IN MEDICAID
4 MANAGED CARE ORGANIZATION PROVIDER NETWORK. (a) The commission
5 shall require that each Medicaid managed care organization that
6 contracts to provide health care services to recipients in a
7 region:

8 (1) seek participation in the organization's provider
9 network from:

10 (A) each health care provider in the region who
11 has traditionally provided care to recipients;

12 (B) each hospital in the region that has been
13 designated as a disproportionate share hospital under Medicaid; and

14 (C) each specialized pediatric laboratory in the
15 region, including a laboratory located in a children's hospital;

16 (2) include in the organization's provider network for
17 at least three years:

18 (A) each health care provider in the region who:

19 (i) previously provided care to Medicaid
20 and charity care recipients at a significant level as the
21 commission prescribes;

22 (ii) agrees to accept the organization's
23 prevailing provider contract rate; and

24 (iii) has the credentials the organization
25 requires, provided that lack of board certification or
26 accreditation by The Joint Commission may not be the sole ground for
27 exclusion from the provider network;

28 (B) each accredited primary care residency
29 program in the region; and

30 (C) each disproportionate share hospital the
31 commission designates as a statewide significant traditional
32 provider; and

33 (3) subject to Section 32.047, Human Resources Code,
34 and notwithstanding any other law, include in the organization's

1 provider network each optometrist, therapeutic optometrist, and
2 ophthalmologist described by Section ____ [[[Section
3 531.021191(b)(1)(A) or (B)]]] who, and an institution of higher
4 education described by Section ____ [[[Section 531.021191(a)(4)]]]
5 in the region that:

6 (A) agrees to comply with the organization's
7 terms;

8 (B) agrees to accept the organization's
9 prevailing provider contract rate;

10 (C) agrees to abide by the organization's
11 required standards of care; and

12 (D) is an enrolled Medicaid provider.

13 (b) A contract between a Medicaid managed care organization
14 and the commission for the organization to provide health care
15 services to recipients in a health care service region that
16 includes a rural area must require the organization to include in
17 the organization's provider network rural hospitals, physicians,
18 home and community support services agencies, and other rural
19 health care providers who:

20 (1) are sole community providers;

21 (2) provide care to Medicaid and charity care
22 recipients at a significant level as the commission prescribes;

23 (3) agree to accept the organization's prevailing
24 provider contract rate; and

25 (4) have the credentials the organization requires,
26 provided that lack of board certification or accreditation by The
27 Joint Commission may not be the sole ground for exclusion from the
28 provider network. (Gov. Code, Secs. 533.006, 533.0067.)

29 Source Law

30 Sec. 533.006. PROVIDER NETWORKS. (a) The
31 commission shall require that each managed care
32 organization that contracts with the commission to
33 provide health care services to recipients in a
34 region:

35 (1) seek participation in the
36 organization's provider network from:

37 (A) each health care provider in the
38 region who has traditionally provided care to

1 recipients;

2 (B) each hospital in the region that
3 has been designated as a disproportionate share
4 hospital under Medicaid; and

5 (C) each specialized pediatric
6 laboratory in the region, including those laboratories
7 located in children's hospitals; and

8 (2) include in its provider network for
9 not less than three years:

10 (A) each health care provider in the
11 region who:

12 (i) previously provided care to
13 Medicaid and charity care recipients at a significant
14 level as prescribed by the commission;

15 (ii) agrees to accept the
16 prevailing provider contract rate of the managed care
17 organization; and

18 (iii) has the credentials
19 required by the managed care organization, provided
20 that lack of board certification or accreditation by
21 The Joint Commission may not be the sole ground for
22 exclusion from the provider network;

23 (B) each accredited primary care
24 residency program in the region; and

25 (C) each disproportionate share
26 hospital designated by the commission as a statewide
27 significant traditional provider.

28 (b) A contract between a managed care
29 organization and the commission for the organization
30 to provide health care services to recipients in a
31 health care service region that includes a rural area
32 must require that the organization include in its
33 provider network rural hospitals, physicians, home and
34 community support services agencies, and other rural
35 health care providers who:

36 (1) are sole community providers;

37 (2) provide care to Medicaid and charity
38 care recipients at a significant level as prescribed
39 by the commission;

40 (3) agree to accept the prevailing
41 provider contract rate of the managed care
42 organization; and

43 (4) have the credentials required by the
44 managed care organization, provided that lack of board
45 certification or accreditation by The Joint Commission
46 may not be the sole ground for exclusion from the
47 provider network.

48 Sec. 533.0067. EYE HEALTH CARE SERVICE
49 PROVIDERS. Subject to Section 32.047, Human Resources
50 Code, but notwithstanding any other law, the
51 commission shall require that each managed care
52 organization that contracts with the commission under
53 any Medicaid managed care model or arrangement to
54 provide health care services to recipients in a region
55 include in the organization's provider network each
56 optometrist, therapeutic optometrist, and
57 ophthalmologist described by Section
58 531.021191(b)(1)(A) or (B) and an institution of
59 higher education described by Section
60 531.021191(a)(4) in the region who:

61 (1) agrees to comply with the terms and
62 conditions of the organization;

63 (2) agrees to accept the prevailing
64 provider contract rate of the organization;

65 (3) agrees to abide by the standards of
66 care required by the organization; and

67 (4) is an enrolled provider under

1 Medicaid.

2 Revisor's Note

3 (1) Section 533.0067, Government Code, refers
4 to a managed care organization that contracts with the
5 Health and Human Services Commission "under any
6 Medicaid managed care model or arrangement" to provide
7 health care services to certain Medicaid recipients.
8 Because a contract to provide health care services to a
9 recipient could only be under a Medicaid managed care
10 model or arrangement, the revised law omits the quoted
11 language as superfluous.

12 (2) Section 533.0067(1), Government Code,
13 refers to the "terms and conditions" imposed by a
14 managed care organization. The revised law omits
15 "conditions" from the quoted phrase for the reason
16 stated in Revisor's Note (3) to Section 540.0206 of
17 this chapter.

18 Revised Law

19 Sec. 540.0652. PROVIDER ACCESS STANDARDS; BIENNIAL REPORT.

20 (a) The commission shall establish minimum provider access
21 standards for a Medicaid managed care organization's provider
22 network. The provider access standards must ensure that a Medicaid
23 managed care organization provides recipients sufficient access
24 to:

- 25 (1) preventive care;
- 26 (2) primary care;
- 27 (3) specialty care;
- 28 (4) after-hours urgent care;
- 29 (5) chronic care;
- 30 (6) long-term services and supports;
- 31 (7) nursing services;
- 32 (8) therapy services, including services provided in a
33 clinical setting or in a home or community-based setting; and
- 34 (9) any other services the commission identifies.

1 (b) To the extent feasible, the provider access standards
2 must:

3 (1) distinguish between access to providers in urban
4 and rural settings;

5 (2) consider the number and geographic distribution of
6 Medicaid-enrolled providers in a particular service delivery area;
7 and

8 (3) subject to Section _____ [[[Section
9 531.0216(c)]]] and consistent with Section 111.007, Occupations
10 Code, consider and include the availability of telehealth services
11 and telemedicine medical services in a Medicaid managed care
12 organization's provider network.

13 (c) The commission shall biennially submit to the
14 legislature and make available to the public a report that
15 contains:

16 (1) information and statistics on:

17 (A) recipient access to providers through
18 Medicaid managed care organizations' provider networks; and

19 (B) Medicaid managed care organization
20 compliance with contractual obligations related to provider access
21 standards;

22 (2) a compilation and analysis of information Medicaid
23 managed care organizations submit to the commission under Section
24 540.0260(4);

25 (3) for both primary care providers and specialty
26 providers, information on provider-to-recipient ratios in a
27 Medicaid managed care organization's provider network and
28 benchmark ratios to indicate whether deficiencies exist in a given
29 network; and

30 (4) a description of, and analysis of the results
31 from, the commission's monitoring process established under
32 Section 540.0601. (Gov. Code, Sec. 533.0061.)

33 Source Law

34 Sec. 533.0061. PROVIDER ACCESS STANDARDS;

1 REPORT. (a) The commission shall establish minimum
2 provider access standards for the provider network of
3 a managed care organization that contracts with the
4 commission to provide health care services to
5 recipients. The access standards must ensure that a
6 managed care organization provides recipients
7 sufficient access to:

- 8 (1) preventive care;
- 9 (2) primary care;
- 10 (3) specialty care;
- 11 (4) after-hours urgent care;
- 12 (5) chronic care;
- 13 (6) long-term services and supports;
- 14 (7) nursing services;
- 15 (8) therapy services, including services
16 provided in a clinical setting or in a home or
17 community-based setting; and
- 18 (9) any other services identified by the
19 commission.

20 (b) To the extent it is feasible, the provider
21 access standards established under this section must:

- 22 (1) distinguish between access to
23 providers in urban and rural settings;
- 24 (2) consider the number and geographic
25 distribution of Medicaid-enrolled providers in a
26 particular service delivery area; and
- 27 (3) subject to Section 531.0216(c) and
28 consistent with Section 111.007, Occupations Code,
29 consider and include the availability of telehealth
30 services and telemedicine medical services within the
31 provider network of a Medicaid managed care
32 organization.

33 (c) The commission shall biennially submit to
34 the legislature and make available to the public a
35 report containing information and statistics about
36 recipient access to providers through the provider
37 networks of the managed care organizations and managed
38 care organization compliance with contractual
39 obligations related to provider access standards
40 established under this section. The report must
41 contain:

- 42 (1) a compilation and analysis of
43 information submitted to the commission under Section
44 533.005(a)(20)(D);
- 45 (2) for both primary care providers and
46 specialty providers, information on
47 provider-to-recipient ratios in an organization's
48 provider network, as well as benchmark ratios to
49 indicate whether deficiencies exist in a given
50 network; and
- 51 (3) a description of, and analysis of the
52 results from, the commission's monitoring process
53 established under Section 533.007(1).

54 Revised Law

55 Sec. 540.0653. PENALTIES AND OTHER REMEDIES FOR FAILURE TO
56 COMPLY WITH PROVIDER ACCESS STANDARDS. If a Medicaid managed care
57 organization fails to comply with one or more provider access
58 standards the commission establishes under Section 540.0652 and the
59 commission determines the organization has not made substantial
60 efforts to mitigate or remedy the noncompliance, the commission:

1 (1) may:
2 (A) elect to not retain or renew the commission's
3 contract with the organization; or
4 (B) require the organization to pay liquidated
5 damages in accordance with Section 540.0260(3); and
6 (2) if the organization's noncompliance occurs in a
7 given service delivery area for two consecutive calendar quarters,
8 shall suspend default enrollment to the organization in that
9 service delivery area for at least one calendar quarter. (Gov.
10 Code, Sec. 533.0062.)

11 Source Law

12 Sec. 533.0062. PENALTIES AND OTHER REMEDIES FOR
13 FAILURE TO COMPLY WITH PROVIDER ACCESS STANDARDS. If a
14 managed care organization that has contracted with the
15 commission to provide health care services to
16 recipients fails to comply with one or more provider
17 access standards established under Section 533.0061
18 and the commission determines the organization has not
19 made substantial efforts to mitigate or remedy the
20 noncompliance, the commission:

21 (1) may:
22 (A) elect to not retain or renew the
23 commission's contract with the organization; or
24 (B) require the organization to pay
25 liquidated damages in accordance with Section
26 533.005(a)(20)(C); and
27 (2) shall suspend default enrollment to
28 the organization in a given service delivery area for
29 at least one calendar quarter if the organization's
30 noncompliance occurs in the service delivery area for
31 two consecutive calendar quarters.

32 Revised Law

33 Sec. 540.0654. PROVIDER NETWORK DIRECTORIES. (a) The
34 commission shall ensure that a Medicaid managed care organization:

35 (1) posts on the organization's Internet website:

36 (A) the organization's provider network
37 directory; and

38 (B) a direct telephone number and e-mail address
39 through which a recipient enrolled in the organization's managed
40 care plan or the recipient's provider may contact the organization
41 to receive assistance with:

42 (i) identifying in-network providers and
43 services available to the recipient; and

1 (ii) scheduling an appointment for the
2 recipient with an available in-network provider or to access
3 available in-network services; and

4 (2) updates the online directory required under
5 Subdivision (1)(A) at least monthly.

6 (b) A Medicaid managed care organization is required to send
7 a paper form of the organization's provider network directory for
8 the program only to a recipient who requests to receive the
9 directory in paper form. (Gov. Code, Sec. 533.0063.)

10 Source Law

11 Sec. 533.0063. PROVIDER NETWORK DIRECTORIES.

12 (a) The commission shall ensure that a managed care
13 organization that contracts with the commission to
14 provide health care services to recipients:

15 (1) posts on the organization's Internet
16 website:

17 (A) the organization's provider
18 network directory; and

19 (B) a direct telephone number and
20 e-mail address through which a recipient enrolled in
21 the organization's managed care plan or the recipient's
22 provider may contact the organization to receive
23 assistance with:

24 (i) identifying in-network
25 providers and services available to the recipient; and

26 (ii) scheduling an appointment
27 for the recipient with an available in-network
28 provider or to access available in-network services;
29 and

30 (2) updates the online directory required
31 under Subdivision (1)(A) at least monthly.

32 (b) A managed care organization is required to
33 send a paper form of the organization's provider
34 network directory for the program only to a recipient
35 who requests to receive the directory in paper form.

36 Revised Law

37 Sec. 540.0655. PROVIDER PROTECTION PLAN. (a) The
38 commission shall develop and implement a provider protection plan
39 designed to:

40 (1) reduce administrative burdens on providers
41 participating in a Medicaid managed care model or arrangement
42 implemented under this chapter or Chapter _____ [[[Sections
43 533.00257, 533.002571, 533.00258, and 533.002581]]]; and

44 (2) ensure efficient provider enrollment and
45 reimbursement.

46 (b) To the greatest extent possible, the commission shall

1 incorporate the measures in the provider protection plan into each
2 contract between a managed care organization and the commission to
3 provide health care services to recipients.

4 (c) The provider protection plan must provide for:

5 (1) a Medicaid managed care organization's prompt
6 payment to and proper reimbursement of providers;

7 (2) prompt and accurate claim adjudication through:

8 (A) educating providers on properly submitting
9 clean claims and on appeals;

10 (B) accepting uniform forms, including HCFA
11 Forms 1500 and UB-92 and subsequent versions of those forms,
12 through an electronic portal; and

13 (C) establishing standards for claims payments
14 in accordance with a provider's contract;

15 (3) adequate and clearly defined provider network
16 standards that:

17 (A) are specific to provider type, including
18 physicians, general acute care facilities, and other provider types
19 defined in the commission's network adequacy standards in effect on
20 January 1, 2013; and

21 (B) ensure choice among multiple providers to the
22 greatest extent possible;

23 (4) a prompt credentialing process for providers;

24 (5) uniform efficiency standards and requirements for
25 Medicaid managed care organizations for submitting and tracking
26 preauthorization requests for Medicaid services;

27 (6) establishing an electronic process, including the
28 use of an Internet portal, through which providers in any managed
29 care organization's provider network may:

30 (A) submit electronic claims, prior
31 authorization requests, claims appeals and reconsiderations,
32 clinical data, and other documents that the organization requests
33 for prior authorization and claims processing; and

34 (B) obtain electronic remittance advice,

1 explanation of benefits statements, and other standardized
2 reports;

3 (7) measuring Medicaid managed care organization
4 retention rates of significant traditional providers;

5 (8) creating a work group to review and make
6 recommendations to the commission concerning any requirement under
7 this subsection for which immediate implementation is not feasible
8 at the time the plan is otherwise implemented, including the
9 required process for submitting and accepting attachments for
10 claims processing and prior authorization requests through an
11 electronic process under Subdivision (6) and, for any requirement
12 that is not implemented immediately, recommendations regarding the
13 expected:

14 (A) fiscal impact of implementing the
15 requirement; and

16 (B) timeline for implementing the requirement;
17 and

18 (9) any other provision the commission determines will
19 ensure efficiency or reduce administrative burdens on providers
20 participating in a Medicaid managed care model or arrangement.

21 (Gov. Code, Sec. 533.0055.)

22 Source Law

23 Sec. 533.0055. PROVIDER PROTECTION PLAN. (a)
24 The commission shall develop and implement a provider
25 protection plan that is designed to reduce
26 administrative burdens placed on providers
27 participating in a Medicaid managed care model or
28 arrangement implemented under this chapter and to
29 ensure efficiency in provider enrollment and
30 reimbursement. The commission shall incorporate the
31 measures identified in the plan, to the greatest
32 extent possible, into each contract between a managed
33 care organization and the commission for the provision
34 of health care services to recipients.

35 (b) The provider protection plan required under
36 this section must provide for:

37 (1) prompt payment and proper
38 reimbursement of providers by managed care
39 organizations;

40 (2) prompt and accurate adjudication of
41 claims through:

42 (A) provider education on the proper
43 submission of clean claims and on appeals;

44 (B) acceptance of uniform forms,
45 including HCFA Forms 1500 and UB-92 and subsequent

1 versions of those forms, through an electronic portal;
2 and

3 (C) the establishment of standards
4 for claims payments in accordance with a provider's
5 contract;

6 (3) adequate and clearly defined provider
7 network standards that are specific to provider type,
8 including physicians, general acute care facilities,
9 and other provider types defined in the commission's
10 network adequacy standards in effect on January 1,
11 2013, and that ensure choice among multiple providers
12 to the greatest extent possible;

13 (4) a prompt credentialing process for
14 providers;

15 (5) uniform efficiency standards and
16 requirements for managed care organizations for the
17 submission and tracking of preauthorization requests
18 for services provided under Medicaid;

19 (6) establishment of an electronic
20 process, including the use of an Internet portal,
21 through which providers in any managed care
22 organization's provider network may:

23 (A) submit electronic claims, prior
24 authorization requests, claims appeals and
25 reconsiderations, clinical data, and other
26 documentation that the managed care organization
27 requests for prior authorization and claims
28 processing; and

29 (B) obtain electronic remittance
30 advice, explanation of benefits statements, and other
31 standardized reports;

32 (7) the measurement of the rates of
33 retention by managed care organizations of significant
34 traditional providers;

35 (8) the creation of a work group to review
36 and make recommendations to the commission concerning
37 any requirement under this subsection for which
38 immediate implementation is not feasible at the time
39 the plan is otherwise implemented, including the
40 required process for submission and acceptance of
41 attachments for claims processing and prior
42 authorization requests through an electronic process
43 under Subdivision (6) and, for any requirement that is
44 not implemented immediately, recommendations
45 regarding the expected:

46 (A) fiscal impact of implementing the
47 requirement; and

48 (B) timeline for implementation of
49 the requirement; and

50 (9) any other provision that the
51 commission determines will ensure efficiency or reduce
52 administrative burdens on providers participating in a
53 Medicaid managed care model or arrangement.

54 Revised Law

55 Sec. 540.0656. EXPEDITED CREDENTIALING PROCESS FOR CERTAIN
56 PROVIDERS. (a) In this section, "applicant provider" means a
57 physician or other health care provider applying for expedited
58 credentialing.

59 (b) Notwithstanding any other law and subject to Subsection
60 (c), a Medicaid managed care organization shall establish and

1 implement an expedited credentialing process that allows an
2 applicant provider to provide services to recipients on a
3 provisional basis.

4 (c) The commission shall identify the types of providers for
5 which a Medicaid managed care organization must establish and
6 implement an expedited credentialing process.

7 (d) To qualify for expedited credentialing and payment
8 under Subsection (e), an applicant provider must:

9 (1) be a member of an established health care provider
10 group that has a current contract with a Medicaid managed care
11 organization;

12 (2) be a Medicaid-enrolled provider;

13 (3) agree to comply with the terms of the contract
14 described by Subdivision (1); and

15 (4) submit all documentation and other information the
16 Medicaid managed care organization requires as necessary to enable
17 the organization to begin the credentialing process the
18 organization requires to include a provider in the organization's
19 provider network.

20 (e) On an applicant provider's submission of the
21 information the Medicaid managed care organization requires under
22 Subsection (d), and for Medicaid reimbursement purposes only, the
23 organization shall treat the provider as if the provider were in the
24 organization's provider network when the provider provides
25 services to recipients, subject to Subsections (f) and (g).

26 (f) Except as provided by Subsection (g), a Medicaid managed
27 care organization that determines on completion of the
28 credentialing process that an applicant provider does not meet the
29 organization's credentialing requirements may recover from the
30 provider the difference between payments for in-network benefits
31 and out-of-network benefits.

32 (g) A Medicaid managed care organization that determines on
33 completion of the credentialing process that an applicant provider
34 does not meet the organization's credentialing requirements and

1 that the provider made fraudulent claims in the provider's
2 application for credentialing may recover from the provider the
3 entire amount the organization paid the provider. (Gov. Code, Sec.
4 533.0064.)

5 Source Law

6 Sec. 533.0064. EXPEDITED CREDENTIALING PROCESS
7 FOR CERTAIN PROVIDERS. (a) In this section,
8 "applicant provider" means a physician or other health
9 care provider applying for expedited credentialing
10 under this section.

11 (b) Notwithstanding any other law and subject to
12 Subsection (c), a managed care organization that
13 contracts with the commission to provide health
14 services to recipients shall, in accordance with this
15 section, establish and implement an expedited
16 credentialing process that would allow applicant
17 providers to provide services to recipients on a
18 provisional basis.

19 (c) The commission shall identify the types of
20 providers for which an expedited credentialing process
21 must be established and implemented under this
22 section.

23 (d) To qualify for expedited credentialing
24 under this section and payment under Subsection (e),
25 an applicant provider must:

26 (1) be a member of an established health
27 care provider group that has a current contract in
28 force with a managed care organization described by
29 Subsection (b);

30 (2) be a Medicaid-enrolled provider;

31 (3) agree to comply with the terms of the
32 contract described by Subdivision (1); and

33 (4) submit all documentation and other
34 information required by the managed care organization
35 as necessary to enable the organization to begin the
36 credentialing process required by the organization to
37 include a provider in the organization's provider
38 network.

39 (e) On submission by the applicant provider of
40 the information required by the managed care
41 organization under Subsection (d), and for Medicaid
42 reimbursement purposes only, the organization shall
43 treat the provider as if the provider were in the
44 organization's provider network when the provider
45 provides services to recipients, subject to
46 Subsections (f) and (g).

47 (f) Except as provided by Subsection (g), if, on
48 completion of the credentialing process, a managed
49 care organization determines that the applicant
50 provider does not meet the organization's
51 credentialing requirements, the organization may
52 recover from the provider the difference between
53 payments for in-network benefits and out-of-network
54 benefits.

55 (g) If a managed care organization determines on
56 completion of the credentialing process that the
57 applicant provider does not meet the organization's
58 credentialing requirements and that the provider made
59 fraudulent claims in the provider's application for
60 credentialing, the organization may recover from the
61 provider the entire amount of any payment paid to the
62 provider.

1 Revised Law

2 Sec. 540.0657. FREQUENCY OF PROVIDER RECREDENTIALING. (a)
3 A Medicaid managed care organization shall formally recredential a
4 physician or other provider with the frequency required by the
5 single, consolidated Medicaid provider enrollment and
6 credentialing process, if that process is created under Section ____
7 [[[Section 531.02118]]].

8 (b) Notwithstanding any other law, the required frequency
9 of recredentialing may be less frequent than once in any three-year
10 period. (Gov. Code, Sec. 533.0065.)

11 Source Law

12 Sec. 533.0065. FREQUENCY OF PROVIDER
13 CREDENTIALING. A managed care organization that
14 contracts with the commission to provide health care
15 services to Medicaid recipients under a managed care
16 plan issued by the organization shall formally
17 recredential a physician or other provider with the
18 frequency required by the single, consolidated
19 Medicaid provider enrollment and credentialing
20 process, if that process is created under Section
21 531.02118. The required frequency of recredentialing
22 may be less frequent than once in any three-year
23 period, notwithstanding any other law.

24 Revised Law

25 Sec. 540.0658. PROVIDER INCENTIVES FOR PROMOTING
26 PREVENTIVE SERVICES. To the extent possible, the commission shall
27 work to ensure that a Medicaid managed care organization provides
28 payment incentives to a health care provider in the organization's
29 provider network whose performance in promoting recipient use of
30 preventive services exceeds minimum established standards. (Gov.
31 Code, Sec. 533.0066.)

32 Source Law

33 Sec. 533.0066. PROVIDER INCENTIVES. The
34 commission shall, to the extent possible, work to
35 ensure that managed care organizations provide payment
36 incentives to health care providers in the
37 organizations' networks whose performance in promoting
38 recipients' use of preventive services exceeds minimum
39 established standards.

40 Revised Law

41 Sec. 540.0659. REIMBURSEMENT RATE FOR CERTAIN SERVICES
42 PROVIDED BY CERTAIN HEALTH CENTERS AND CLINICS OUTSIDE REGULAR

1 BUSINESS HOURS. (a) This section applies only to a recipient
2 receiving benefits through a Medicaid managed care model or
3 arrangement.

4 (b) The commission shall ensure that a federally qualified
5 health center, rural health clinic, or municipal health
6 department's public clinic is reimbursed for health care services
7 provided to a recipient outside of regular business hours,
8 including on a weekend or holiday, at a rate that is equal to the
9 allowable rate for those services as determined under Section
10 32.028, Human Resources Code, regardless of whether the recipient
11 has a referral from the recipient's primary care provider.

12 (c) The executive commissioner shall adopt rules regarding
13 the days, times of days, and holidays that are considered to be
14 outside of regular business hours for purposes of Subsection (b).
15 (Gov. Code, Sec. 533.01315.)

16 Source Law

17 Sec. 533.01315. REIMBURSEMENT FOR SERVICES
18 PROVIDED OUTSIDE OF REGULAR BUSINESS HOURS. (a) This
19 section applies only to a recipient receiving benefits
20 through any Medicaid managed care model or
21 arrangement.

22 (b) The commission shall ensure that a federally
23 qualified health center, rural health clinic, or
24 municipal health department's public clinic is
25 reimbursed for health care services provided to a
26 recipient outside of regular business hours, including
27 on a weekend or holiday, at a rate that is equal to the
28 allowable rate for those services as determined under
29 Section 32.028, Human Resources Code, regardless of
30 whether the recipient has a referral from the
31 recipient's primary care provider.

32 (c) The executive commissioner shall adopt
33 rules regarding the days, times of days, and holidays
34 that are considered to be outside of regular business
35 hours for purposes of Subsection (b).

36 SUBCHAPTER O. DELIVERY OF SERVICES: GENERAL PROVISIONS

37 Revised Law

38 Sec. 540.0701. ACUTE CARE SERVICE DELIVERY THROUGH MOST
39 COST-EFFECTIVE MODEL; MANAGED CARE SERVICE DELIVERY AREAS. (a)
40 Except as otherwise provided by this section and notwithstanding
41 any other law, the commission shall provide Medicaid acute care
42 services through the most cost-effective model of Medicaid
43 capitated managed care as the commission determines. The

1 commission shall require mandatory participation in a Medicaid
2 capitated managed care program for all individuals eligible for
3 Medicaid acute care benefits, but may implement alternative models
4 or arrangements, including a traditional fee-for-service
5 arrangement, if the commission determines the alternative would be
6 more cost-effective or efficient.

7 (b) In determining whether a model or arrangement described
8 by Subsection (a) is more cost-effective, the executive
9 commissioner must consider:

10 (1) the scope, duration, and types of health benefits
11 or services to be provided in a certain part of this state or to a
12 certain recipient population;

13 (2) administrative costs necessary to meet federal and
14 state statutory and regulatory requirements;

15 (3) the anticipated effect of market competition
16 associated with the configuration of Medicaid service delivery
17 models the commission determines; and

18 (4) the gain or loss to this state of a tax collected
19 under Chapter 222, Insurance Code.

20 (c) If the commission determines that it is not more
21 cost-effective to use a Medicaid managed care model to provide
22 certain types of Medicaid acute care in a certain area or to certain
23 recipients as prescribed by this section, the commission shall
24 provide Medicaid acute care through a traditional fee-for-service
25 arrangement.

26 (d) The commission shall determine the most cost-effective
27 alignment of managed care service delivery areas. The executive
28 commissioner may consider:

29 (1) the number of lives impacted;

30 (2) the usual source of health care services for
31 residents in an area; and

32 (3) other factors that impact health care service
33 delivery in the area. (Gov. Code, Secs. 533.0025(b), (c), (d),
34 (e).)

1 exceptions to Section 533.0025(b) are revised in this
2 section.

3 Revised Law

4 Sec. 540.0702. TRANSITION OF CASE MANAGEMENT FOR CHILDREN
5 AND PREGNANT WOMEN PROGRAM RECIPIENTS TO MEDICAID MANAGED CARE
6 PROGRAM. (a) In this section, "children and pregnant women
7 program" means the Medicaid benefits program administered by the
8 Department of State Health Services that provides case management
9 services to children who have a health condition or health risk and
10 pregnant women who have a high-risk condition.

11 (b) The commission shall transition to a Medicaid managed
12 care model all case management services provided to children and
13 pregnant women program recipients. In transitioning the services,
14 the commission shall ensure a recipient is provided case management
15 services through the Medicaid managed care plan in which the
16 recipient is enrolled.

17 (c) In implementing this section, the commission shall
18 ensure that:

19 (1) there is a seamless transition in case management
20 services for children and pregnant women program recipients; and

21 (2) case management services provided under the
22 program are not interrupted. (Gov. Code, Sec. 533.002555.)

23 Source Law

24 Sec. 533.002555. TRANSITION OF CASE MANAGEMENT
25 FOR CHILDREN AND PREGNANT WOMEN PROGRAM RECIPIENTS TO
26 MANAGED CARE PROGRAM. (a) In this section, "children
27 and pregnant women program" means the benefits program
28 provided under Medicaid and administered by the
29 Department of State Health Services that provides case
30 management services to children who have a health
31 condition or health risk and pregnant women who have a
32 high-risk condition.

33 (b) The commission shall transition to a
34 Medicaid managed care model all case management
35 services provided to recipients under the children and
36 pregnant women program. In transitioning services
37 under this section, the commission shall ensure a
38 recipient is provided case management services through
39 the managed care plan in which the recipient is
40 enrolled.

41 (c) In implementing this section, the
42 commission shall ensure:

43 (1) a seamless transition in case
44 management for recipients receiving benefits under the

1 children and pregnant women program; and
2 (2) case management services provided
3 under the program are not interrupted.

4 Revised Law

5 Sec. 540.0703. BEHAVIORAL HEALTH AND PHYSICAL HEALTH
6 SERVICES. (a) In this section, "behavioral health services" means
7 mental health and substance use disorder services.

8 (b) To the greatest extent possible, the commission shall
9 integrate the following services into the Medicaid managed care
10 program:

11 (1) behavioral health services, including targeted
12 case management and psychiatric rehabilitation services; and

13 (2) physical health services.

14 (c) A Medicaid managed care organization shall:

15 (1) develop a network of public and private behavioral
16 health services providers; and

17 (2) ensure adults with serious mental illness and
18 children with serious emotional disturbance have access to a
19 comprehensive array of services.

20 (d) In implementing this section, the commission shall
21 ensure that:

22 (1) an appropriate assessment tool is used to
23 authorize services;

24 (2) providers are well-qualified and able to provide
25 an appropriate array of services;

26 (3) appropriate performance and quality outcomes are
27 measured;

28 (4) two health home pilot programs are established in
29 two health service areas, representing two distinct regions of this
30 state, for individuals who are diagnosed with:

31 (A) a serious mental illness; and

32 (B) at least one other chronic health condition;

33 (5) a health home established under a pilot program
34 under Subdivision (4) complies with the principles for
35 patient-centered medical homes described in Section 540.0712; and

1 (6) all behavioral health services provided under this
2 section are based on an approach to treatment in which the expected
3 outcome of treatment is recovery.

4 (e) If the commission determines that it is cost-effective
5 and beneficial to recipients, the commission shall include a peer
6 specialist as a benefit to recipients or as a provider type.

7 (f) To the extent of any conflict between this section and
8 any other law relating to behavioral health services, this section
9 prevails.

10 (g) The executive commissioner shall adopt rules necessary
11 to implement this section. (Gov. Code, Sec. 533.00255.)

12 Source Law

13 Sec. 533.00255. BEHAVIORAL HEALTH AND PHYSICAL
14 HEALTH SERVICES NETWORK. (a) In this section,
15 "behavioral health services" means mental health and
16 substance abuse disorder services.

17 (b) The commission shall, to the greatest extent
18 possible, integrate into the Medicaid managed care
19 program implemented under this chapter the following
20 services for Medicaid-eligible persons:

21 (1) behavioral health services, including
22 targeted case management and psychiatric
23 rehabilitation services; and

24 (2) physical health services.

25 (c) A managed care organization that contracts
26 with the commission under this chapter shall develop a
27 network of public and private providers of behavioral
28 health services and ensure adults with serious mental
29 illness and children with serious emotional
30 disturbance have access to a comprehensive array of
31 services.

32 (d) In implementing this section, the
33 commission shall ensure that:

34 (1) an appropriate assessment tool is used
35 to authorize services;

36 (2) providers are well-qualified and able
37 to provide an appropriate array of services;

38 (3) appropriate performance and quality
39 outcomes are measured;

40 (4) two health home pilot programs are
41 established in two health service areas, representing
42 two distinct regions of the state, for persons who are
43 diagnosed with:

44 (A) a serious mental illness; and
45 (B) at least one other chronic health
46 condition;

47 (5) a health home established under a
48 pilot program under Subdivision (4) complies with the
49 principles for patient-centered medical homes
50 described in Section 533.0029; and

51 (6) all behavioral health services
52 provided under this section are based on an approach to
53 treatment where the expected outcome of treatment is
54 recovery.

55 (g) The commission shall, if the commission

1 determines that it is cost-effective and beneficial to
2 recipients, include a peer specialist as a benefit to
3 recipients or as a provider type.

4 (h) To the extent of any conflict between this
5 section and any other law relating to behavioral
6 health services, this section prevails.

7 (i) The executive commissioner shall adopt
8 rules necessary to implement this section.

9 Revisor's Note

10 (1) Section 533.00255(a), Government Code,
11 refers to "substance abuse" disorder services. The
12 revised law substitutes "substance use" for "substance
13 abuse" for the reason stated in the revisor's note to
14 Section 540.0262 of this chapter.

15 (2) Section 533.00255(b), Government Code,
16 requires the Health and Human Services Commission to
17 integrate certain services "for Medicaid-eligible
18 persons" into the Medicaid managed care program
19 "implemented under this chapter," meaning Chapter 533,
20 Government Code. Chapter 533, Government Code,
21 revised in relevant part as this chapter, is the only
22 chapter under which the Medicaid managed care program
23 is implemented, and only Medicaid-eligible persons may
24 receive services through the Medicaid managed care
25 program. The revised law omits the quoted language as
26 superfluous.

27 Revised Law

28 Sec. 540.0704. TARGETED CASE MANAGEMENT AND PSYCHIATRIC
29 REHABILITATIVE SERVICES FOR CHILDREN, ADOLESCENTS, AND FAMILIES.

30 (a) A provider in the provider network of a Medicaid managed care
31 organization that contracts with the commission to provide
32 behavioral health services under Section 540.0703 may contract with
33 the organization to provide targeted case management and
34 psychiatric rehabilitative services to children, adolescents, and
35 their families.

36 (b) Commission rules and guidelines concerning contract and
37 training requirements applicable to the provision of behavioral
38 health services may apply to a provider that contracts with a

1 Medicaid managed care organization under Subsection (a) only to the
2 extent those contract and training requirements are specific to the
3 provision of targeted case management and psychiatric
4 rehabilitative services to children, adolescents, and their
5 families.

6 (c) Commission rules and guidelines applicable to a
7 provider that contracts with a Medicaid managed care organization
8 under Subsection (a) may not require the provider to provide a
9 behavioral health crisis hotline or a mobile crisis team that
10 operates 24 hours per day and seven days per week. This subsection
11 does not prohibit a Medicaid managed care organization that
12 contracts with the commission to provide behavioral health services
13 under Section 540.0703 from specifically contracting with a
14 provider for the provision of a behavioral health crisis hotline or
15 a mobile crisis team that operates 24 hours per day and seven days
16 per week.

17 (d) Commission rules and guidelines applicable to a
18 provider that contracts with a Medicaid managed care organization
19 to provide targeted case management and psychiatric rehabilitative
20 services specific to children and adolescents who are at risk of
21 juvenile justice involvement, expulsion from school, displacement
22 from the home, hospitalization, residential treatment, or serious
23 injury to self, others, or animals may not require the provider to
24 also provide less intensive psychiatric rehabilitative services
25 specified by commission rules and guidelines as applicable to the
26 provision of targeted case management and psychiatric
27 rehabilitative services to children, adolescents, and their
28 families, if that provider has a referral arrangement to provide
29 access to those less intensive psychiatric rehabilitative
30 services.

31 (e) Commission rules and guidelines applicable to a
32 provider that contracts with a Medicaid managed care organization
33 under Subsection (a) may not require the provider to provide
34 services not covered under Medicaid. (Gov. Code, Sec. 533.002552.)

1 an arrangement with a subsidiary of the organization, the
2 commission shall:

3 (1) require the effective sharing and integration of
4 care coordination, service authorization, and utilization
5 management data between the organization and the third party or
6 subsidiary;

7 (2) encourage the collocation of physical health and
8 behavioral health care coordination staff, to the extent feasible;

9 (3) require warm call transfers between physical
10 health and behavioral health care coordination staff;

11 (4) require the organization and the third party or
12 subsidiary to implement joint rounds for physical health and
13 behavioral health services network providers or some other
14 effective means for sharing clinical information; and

15 (5) ensure that the organization makes available a
16 seamless provider portal for both physical health and behavioral
17 health services network providers, to the extent allowed by federal
18 law. (Gov. Code, Sec. 533.002553.)

19 Source Law

20 Sec. 533.002553. BEHAVIORAL HEALTH SERVICES
21 PROVIDED THROUGH THIRD PARTY OR SUBSIDIARY. (a) In
22 this section, "behavioral health services" has the
23 meaning assigned by Section 533.00255.

24 (b) For a managed care organization that
25 contracts with the commission under this chapter and
26 that provides behavioral health services through a
27 contract with a third party or an arrangement with a
28 subsidiary of the managed care organization, the
29 commission shall:

30 (1) require the effective sharing and
31 integration of care coordination, service
32 authorization, and utilization management data
33 between the managed care organization and the third
34 party or subsidiary;

35 (2) encourage, to the extent feasible, the
36 collocation of physical health and behavioral health
37 care coordination staff;

38 (3) require warm call transfers between
39 physical health and behavioral health care
40 coordination staff;

41 (4) require the managed care organization
42 and the third party or subsidiary to implement joint
43 rounds for physical health and behavioral health
44 services network providers or some other effective
45 means for sharing clinical information; and

46 (5) ensure that the managed care
47 organization makes available a seamless provider
48 portal for both physical health and behavioral health

1 services network providers, to the extent allowed by
2 federal law.

3 Revised Law

4 Sec. 540.0706. PSYCHOTROPIC MEDICATION MONITORING SYSTEM
5 FOR CERTAIN CHILDREN. (a) In this section, "psychotropic
6 medication" has the meaning assigned by Section 266.001, Family
7 Code.

8 (b) The commission shall implement a system under which the
9 commission will use Medicaid prescription drug data to monitor the
10 prescribing of psychotropic medications for:

11 (1) children who are in the conservatorship of the
12 Department of Family and Protective Services and enrolled in the
13 STAR Health program or eligible for both Medicaid and Medicare; and

14 (2) children who are under the supervision of the
15 Department of Family and Protective Services through an agreement
16 under the Interstate Compact on the Placement of Children under
17 Subchapter B, Chapter 162, Family Code.

18 (c) The commission shall include as a component of the
19 monitoring system a medical review of a prescription to which
20 Subsection (b) applies when that review is appropriate. (Gov. Code,
21 Sec. 533.0161.)

22 Source Law

23 Sec. 533.0161. MONITORING OF PSYCHOTROPIC DRUG
24 PRESCRIPTIONS FOR CERTAIN CHILDREN. (a) In this
25 section, "psychotropic drug" has the meaning assigned
26 by Section 261.111, Family Code.

27 (b) The commission shall implement a system
28 under which the commission will use Medicaid
29 prescription drug data to monitor the prescribing of
30 psychotropic drugs for:

31 (1) children who are in the
32 conservatorship of the Department of Family and
33 Protective Services and enrolled in the STAR Health
34 Medicaid managed care program or eligible for both
35 Medicaid and Medicare; and

36 (2) children who are under the supervision
37 of the Department of Family and Protective Services
38 through an agreement under the Interstate Compact on
39 the Placement of Children under Subchapter B, Chapter
40 162, Family Code.

41 (c) The commission shall include as a component
42 of the monitoring system required by this section a
43 medical review of a prescription to which Subsection
44 (b) applies when that review is appropriate.

1 Revisor's Note

2 (1) Section 533.0161(a), Government Code,
3 provides that the term "psychotropic drug" has the
4 meaning assigned by Section 261.111, Family Code.
5 Section 261.111, Family Code, provides that the term
6 "psychotropic medication" has the meaning assigned by
7 Section 266.001, Family Code. For the convenience of
8 the reader, the revised law substitutes the term
9 "psychotropic medication" for "psychotropic drug" and
10 substitutes a reference to Section 266.001, Family
11 Code, for the reference to Section 261.111, Family
12 Code.

13 (2) Section 533.0161(b)(1), Government Code,
14 refers to the "STAR Health Medicaid managed care
15 program." The revised law substitutes "STAR Health
16 program" for "STAR Health Medicaid managed care
17 program" because the terms are synonymous and "STAR
18 Health program" is more commonly used.

19 Revised Law

20 Sec. 540.0707. MEDICATION THERAPY MANAGEMENT. The
21 executive commissioner shall collaborate with Medicaid managed
22 care organizations to implement medication therapy management
23 services to lower costs and improve quality outcomes for recipients
24 by reducing adverse drug events. (Gov. Code, Sec. 533.00515.)

25 Source Law

26 Sec. 533.00515. MEDICATION THERAPY MANAGEMENT.
27 The executive commissioner shall collaborate with
28 Medicaid managed care organizations to implement
29 medication therapy management services to lower costs
30 and improve quality outcomes for recipients by
31 reducing adverse drug events.

32 Revised Law

33 Sec. 540.0708. SPECIAL DISEASE MANAGEMENT. (a) The
34 commission shall ensure that a Medicaid managed care organization
35 develops and implements special disease management programs to
36 manage a disease or other chronic health condition with respect to

1 which disease management would be cost-effective for populations
2 the commission identifies. The special disease management programs
3 may manage a disease or other chronic health condition such as:

- 4 (1) heart disease;
- 5 (2) chronic kidney disease and related medical
6 complications;
- 7 (3) respiratory illness, including asthma;
- 8 (4) diabetes;
- 9 (5) end-stage renal disease;
- 10 (6) HIV infection; or
- 11 (7) AIDS.

12 (b) A Medicaid managed care plan must provide, in the manner
13 the commission requires, disease management services including:

- 14 (1) patient self-management education;
- 15 (2) provider education;
- 16 (3) evidence-based models and minimum standards of
17 care;
- 18 (4) standardized protocols and participation
19 criteria; and
- 20 (5) physician-directed or physician-supervised care.

21 (c) The executive commissioner by rule shall prescribe the
22 minimum requirements that a Medicaid managed care organization must
23 meet in providing a special disease management program to be
24 eligible to receive a contract under this section. The
25 organization must at a minimum be required to:

- 26 (1) provide disease management services that have
27 performance measures for particular diseases that are comparable to
28 the relevant performance measures applicable to a provider of
29 disease management services under Section 32.057, Human Resources
30 Code;
- 31 (2) show evidence of ability to manage complex
32 diseases in the Medicaid population; and
- 33 (3) if a special disease management program the
34 organization provides has low active participation rates, identify

1 the reason for the low rates and develop an approach to increase
2 active participation in special disease management programs for
3 high-risk recipients.

4 (d) If a Medicaid managed care organization implements a
5 special disease management program to manage chronic kidney disease
6 and related medical complications as provided by Subsection (a) and
7 the organization develops a program to provide screening for and
8 diagnosis and treatment of chronic kidney disease and related
9 medical complications to recipients under the organization's
10 Medicaid managed care plan, the program for screening, diagnosis,
11 and treatment must use generally recognized clinical practice
12 guidelines and laboratory assessments that identify chronic kidney
13 disease on the basis of impaired kidney function or the presence of
14 kidney damage. (Gov. Code, Sec. 533.009.)

15 Source Law

16 Sec. 533.009. SPECIAL DISEASE MANAGEMENT. (a)
17 The commission shall ensure that managed care
18 organizations under contract with the commission to
19 provide health care services to recipients develop and
20 implement special disease management programs to
21 manage a disease or other chronic health conditions,
22 such as heart disease, chronic kidney disease and its
23 medical complications, respiratory illness, including
24 asthma, diabetes, end-stage renal disease, HIV
25 infection, or AIDS, and with respect to which the
26 commission identifies populations for which disease
27 management would be cost-effective.

28 (b) A managed health care plan provided under
29 this chapter must provide disease management services
30 in the manner required by the commission, including:

- 31 (1) patient self-management education;
32 (2) provider education;
33 (3) evidence-based models and minimum
34 standards of care;
35 (4) standardized protocols and
36 participation criteria; and
37 (5) physician-directed or
38 physician-supervised care.

39 (c) The executive commissioner, by rule, shall
40 prescribe the minimum requirements that a managed care
41 organization, in providing a disease management
42 program, must meet to be eligible to receive a contract
43 under this section. The managed care organization
44 must, at a minimum, be required to:

45 (1) provide disease management services
46 that have performance measures for particular diseases
47 that are comparable to the relevant performance
48 measures applicable to a provider of disease
49 management services under Section 32.057, Human
50 Resources Code;

51 (2) show evidence of ability to manage
52 complex diseases in the Medicaid population; and

1 (3) if a disease management program
2 provided by the organization has low active
3 participation rates, identify the reason for the low
4 rates and develop an approach to increase active
5 participation in disease management programs for
6 high-risk recipients.

7 (f) If a managed care organization implements a
8 special disease management program to manage chronic
9 kidney disease and its medical complications as
10 provided by Subsection (a) and the managed care
11 organization develops a program to provide screening
12 for and diagnosis and treatment of chronic kidney
13 disease and its medical complications to recipients
14 under the organization's managed care plan, the
15 program for screening, diagnosis, and treatment must
16 use generally recognized clinical practice guidelines
17 and laboratory assessments that identify chronic
18 kidney disease on the basis of impaired kidney
19 function or the presence of kidney damage.

20 Revised Law

21 Sec. 540.0709. SPECIAL PROTOCOLS FOR INDIGENT POPULATIONS.

22 In conjunction with an academic center, the commission may study
23 the treatment of indigent populations to develop special protocols
24 for use by Medicaid managed care organizations in providing health
25 care services to recipients. (Gov. Code, Sec. 533.010.)

26 Source Law

27 Sec. 533.010. SPECIAL PROTOCOLS. In
28 conjunction with an academic center, the commission
29 may study the treatment of indigent populations to
30 develop special protocols for managed care
31 organizations to use in providing health care services
32 to recipients.

33 Revised Law

34 Sec. 540.0710. DIRECT ACCESS TO EYE HEALTH CARE SERVICES.

35 (a) Notwithstanding any other law, the commission shall ensure
36 that a Medicaid managed care plan offered by a Medicaid managed care
37 organization and any other Medicaid managed care model or
38 arrangement implemented under this chapter allow a recipient
39 receiving services through the plan or other model or arrangement
40 to, in the manner and to the extent required by Section 32.072,
41 Human Resources Code:

42 (1) select an in-network ophthalmologist or
43 therapeutic optometrist in the managed care network to provide eye
44 health care services other than surgery; and

45 (2) have direct access to the selected in-network
46 ophthalmologist or therapeutic optometrist for the nonsurgical

1 services.

2 (b) This section does not affect the obligation of an
3 ophthalmologist or therapeutic optometrist in a managed care
4 network to comply with the terms of the Medicaid managed care plan.
5 (Gov. Code, Sec. 533.0026.)

6 Source Law

7 Sec. 533.0026. DIRECT ACCESS TO EYE HEALTH CARE
8 SERVICES UNDER MEDICAID MANAGED CARE MODEL OR
9 ARRANGEMENT. (a) Notwithstanding any other law, the
10 commission shall ensure that a managed care plan
11 offered by a managed care organization that contracts
12 with the commission under this chapter and any other
13 Medicaid managed care model or arrangement implemented
14 under this chapter allow a recipient who receives
15 services through the plan or other model or
16 arrangement to, in the manner and to the extent
17 required by Section 32.072, Human Resources Code:

18 (1) select an in-network ophthalmologist
19 or therapeutic optometrist in the managed care network
20 to provide eye health care services, other than
21 surgery; and

22 (2) have direct access to the selected
23 in-network ophthalmologist or therapeutic optometrist
24 for the provision of the nonsurgical services.

25 (b) This section does not affect the obligation
26 of an ophthalmologist or therapeutic optometrist in a
27 managed care network to comply with the terms and
28 conditions of the managed care plan.

29 Revisor's Note

30 Section 533.0026(b), Government Code, refers to
31 the "terms and conditions" of a Medicaid managed care
32 plan. The revised law omits "conditions" from the
33 quoted phrase for the reason stated in Revisor's Note
34 (3) to Section 540.0206 of this chapter.

35 Revised Law

36 Sec. 540.0711. DELIVERY OF BENEFITS USING
37 TELECOMMUNICATIONS OR INFORMATION TECHNOLOGY. (a) In this
38 section, "home telemonitoring service" means a health service that
39 requires:

40 (1) scheduled remote monitoring of data related to a
41 patient's health; and

42 (2) transmission of the data to a licensed home and
43 community support services agency or hospital, as those terms are
44 defined by Section _____ [[[Section 531.02164(a)]]].

1 (b) The commission shall establish policies and procedures
2 to improve access to care under the Medicaid managed care program by
3 encouraging the use under the program of:

- 4 (1) telehealth services;
- 5 (2) telemedicine medical services;
- 6 (3) home telemonitoring services; and
- 7 (4) other telecommunications or information
8 technology.

9 (c) To the extent allowed by federal law, the executive
10 commissioner by rule shall establish policies and procedures that
11 allow a Medicaid managed care organization to conduct assessments
12 and provide care coordination services using telecommunications or
13 information technology. In establishing the policies and
14 procedures, the executive commissioner shall consider:

15 (1) the extent to which a Medicaid managed care
16 organization determines using the telecommunications or
17 information technology is appropriate;

18 (2) whether the recipient requests that the assessment
19 or service be provided using telecommunications or information
20 technology;

21 (3) whether the recipient consents to receiving the
22 assessment or service using telecommunications or information
23 technology;

24 (4) whether conducting the assessment, including an
25 assessment for an initial waiver eligibility determination, or
26 providing the service in person is not feasible because of the
27 existence of an emergency or state of disaster, including a public
28 health emergency or natural disaster; and

29 (5) whether the commission determines using the
30 telecommunications or information technology is appropriate under
31 the circumstances.

32 (d) If a Medicaid managed care organization conducts an
33 assessment of or provides care coordination services to a recipient
34 using telecommunications or information technology, the

1 organization shall:

2 (1) monitor the health care services provided to the
3 recipient for evidence of fraud, waste, and abuse; and

4 (2) determine whether additional social services or
5 supports are needed.

6 (e) To the extent allowed by federal law, the commission
7 shall allow a recipient who is assessed or provided with care
8 coordination services by a Medicaid managed care organization using
9 telecommunications or information technology to provide consent or
10 other authorizations to receive services verbally instead of in
11 writing.

12 (f) The commission shall determine categories of recipients
13 of home and community-based services who must receive in-person
14 visits. Except during circumstances described by Subsection
15 (c)(4), a Medicaid managed care organization shall, for a recipient
16 of home and community-based services for which the commission
17 requires in-person visits, conduct:

18 (1) at least one in-person visit with the recipient to
19 make an initial waiver eligibility determination; and

20 (2) additional in-person visits with the recipient if
21 necessary, as determined by the organization.

22 (g) Notwithstanding this section, the commission may, on a
23 case-by-case basis, require a Medicaid managed care organization to
24 discontinue the use of telecommunications or information
25 technology for assessment or care coordination services if the
26 commission determines that the discontinuation is in the
27 recipient's best interest. (Gov. Code, Secs. 531.001(4-a),
28 533.039.)

29 Source Law

30 Sec. 531.001. DEFINITIONS. In this subtitle:

31 (4-a) "Home telemonitoring service" means
32 a health service that requires scheduled remote
33 monitoring of data related to a patient's health and
34 transmission of the data to a licensed home and
35 community support services agency or a hospital, as
36 those terms are defined by Section 531.02164(a).

1 Sec. 533.039. DELIVERY OF BENEFITS USING
2 TELECOMMUNICATIONS AND INFORMATION TECHNOLOGY. (a)
3 The commission shall establish policies and procedures
4 to improve access to care under the Medicaid managed
5 care program by encouraging the use of telehealth
6 services, telemedicine medical services, home
7 telemonitoring services, and other telecommunications
8 or information technology under the program.

9 (b) To the extent permitted by federal law, the
10 executive commissioner by rule shall establish
11 policies and procedures that allow a Medicaid managed
12 care organization to conduct assessments and provide
13 care coordination services using telecommunications
14 or information technology. In establishing the
15 policies and procedures, the executive commissioner
16 shall consider:

17 (1) the extent to which a managed care
18 organization determines using the telecommunications
19 or information technology is appropriate;

20 (2) whether the recipient requests that
21 the assessment or service be provided using
22 telecommunications or information technology;

23 (3) whether the recipient consents to
24 receiving the assessment or service using
25 telecommunications or information technology;

26 (4) whether conducting the assessment,
27 including an assessment for an initial waiver
28 eligibility determination, or providing the service in
29 person is not feasible because of the existence of an
30 emergency or state of disaster, including a public
31 health emergency or natural disaster; and

32 (5) whether the commission determines
33 using the telecommunications or information
34 technology is appropriate under the circumstances.

35 (c) If a Medicaid managed care organization
36 conducts an assessment of or provides care
37 coordination services to a recipient using
38 telecommunications or information technology, the
39 managed care organization shall:

40 (1) monitor the health care services
41 provided to the recipient for evidence of fraud,
42 waste, and abuse; and

43 (2) determine whether additional social
44 services or supports are needed.

45 (d) To the extent permitted by federal law, the
46 commission shall allow a recipient who is assessed or
47 provided with care coordination services by a Medicaid
48 managed care organization using telecommunications or
49 information technology to provide consent or other
50 authorizations to receive services verbally instead of
51 in writing.

52 (e) The commission shall determine categories
53 of recipients of home and community-based services who
54 must receive in-person visits. Except during
55 circumstances described by Subsection (b)(4), a
56 Medicaid managed care organization shall, for a
57 recipient of home and community-based services for
58 which the commission requires in-person visits,
59 conduct:

60 (1) at least one in-person visit with the
61 recipient to make an initial waiver eligibility
62 determination; and

63 (2) additional in-person visits with the
64 recipient if necessary, as determined by the managed
65 care organization.

66 (f) Notwithstanding the provisions of this
67 section, the commission may, on a case-by-case basis,
68 require a Medicaid managed care organization to

1 (1) between a primary care physician and a patient in
2 which the physician:

3 (A) provides comprehensive primary care to the
4 patient; and

5 (B) facilitates partnerships between the
6 physician, the patient, any acute care and other care providers,
7 and, when appropriate, the patient's family; and

8 (2) that encompasses the following primary
9 principles:

10 (A) the patient has an ongoing relationship with
11 the physician, who is trained to be the first contact for and to
12 provide continuous and comprehensive care to the patient;

13 (B) the physician leads a team of individuals at
14 the practice level who are collectively responsible for the
15 patient's ongoing care;

16 (C) the physician is responsible for providing
17 all of the care the patient needs or for coordinating with other
18 qualified providers to provide care to the patient throughout the
19 patient's life, including preventive care, acute care, chronic
20 care, and end-of-life care;

21 (D) the patient's care is coordinated across
22 health care facilities and the patient's community and is
23 facilitated by registries, information technology, and health
24 information exchange systems to ensure that the patient receives
25 care when and where the patient wants and needs the care and in a
26 culturally and linguistically appropriate manner; and

27 (E) quality and safe care is provided.

28 (b) The commission shall, to the extent possible, work to
29 ensure that Medicaid managed care organizations:

30 (1) promote the development of patient-centered
31 medical homes for recipients; and

32 (2) provide payment incentives for providers that meet
33 the requirements of a patient-centered medical home. (Gov. Code,
34 Sec. 533.0029.)

1 Source Law

2 Sec. 533.0029. PROMOTION AND PRINCIPLES OF
3 PATIENT-CENTERED MEDICAL HOMES FOR RECIPIENTS. (a)
4 For purposes of this section, a "patient-centered
5 medical home" means a medical relationship:

6 (1) between a primary care physician and a
7 child or adult patient in which the physician:

8 (A) provides comprehensive primary
9 care to the patient; and

10 (B) facilitates partnerships between
11 the physician, the patient, acute care and other care
12 providers, and, when appropriate, the patient's
13 family; and

14 (2) that encompasses the following primary
15 principles:

16 (A) the patient has an ongoing
17 relationship with the physician, who is trained to be
18 the first contact for the patient and to provide
19 continuous and comprehensive care to the patient;

20 (B) the physician leads a team of
21 individuals at the practice level who are collectively
22 responsible for the ongoing care of the patient;

23 (C) the physician is responsible for
24 providing all of the care the patient needs or for
25 coordinating with other qualified providers to provide
26 care to the patient throughout the patient's life,
27 including preventive care, acute care, chronic care,
28 and end-of-life care;

29 (D) the patient's care is coordinated
30 across health care facilities and the patient's
31 community and is facilitated by registries,
32 information technology, and health information
33 exchange systems to ensure that the patient receives
34 care when and where the patient wants and needs the
35 care and in a culturally and linguistically
36 appropriate manner; and

37 (E) quality and safe care is
38 provided.

39 (b) The commission shall, to the extent
40 possible, work to ensure that managed care
41 organizations:

42 (1) promote the development of
43 patient-centered medical homes for recipients; and

44 (2) provide payment incentives for
45 providers that meet the requirements of a
46 patient-centered medical home.

47 Revised Law

48 Sec. 540.0713. VALUE-ADDED SERVICES. The commission shall
49 actively encourage Medicaid managed care organizations to offer
50 benefits, including health care services or benefits or other types
51 of services, that:

52 (1) are in addition to the services ordinarily covered
53 by the Medicaid managed care plan the organization offers; and

54 (2) have the potential to improve the health status of
55 recipients enrolled in the plan. (Gov. Code, Sec. 533.019.)

1 Source Law

2 Sec. 533.019. VALUE-ADDED SERVICES. The
3 commission shall actively encourage managed care
4 organizations that contract with the commission to
5 offer benefits, including health care services or
6 benefits or other types of services, that:

7 (1) are in addition to the services
8 ordinarily covered by the managed care plan offered by
9 the managed care organization; and

10 (2) have the potential to improve the
11 health status of enrollees in the plan.

12 Revisor's Note

13 Section 533.019(2), Government Code, refers to
14 "enrollees," meaning Medicaid recipients who are
15 enrolled in a Medicaid managed care plan a Medicaid
16 managed care organization offers. Throughout this
17 chapter, the revised law substitutes "recipients
18 enrolled" and "enrolled recipients" for "enrollees" in
19 a particular Medicaid managed care plan or program for
20 clarity and consistency in the terminology used within
21 the chapter.

22 SUBCHAPTER P. DELIVERY OF SERVICES: STAR+PLUS MEDICAID MANAGED CARE
23 PROGRAM

24 Revised Law

25 Sec. 540.0751. DELIVERY OF ACUTE CARE SERVICES AND
26 LONG-TERM SERVICES AND SUPPORTS. Subject to Sections 540.0701 and
27 540.0753, the commission shall expand the STAR+PLUS Medicaid
28 managed care program to all areas of this state to serve individuals
29 eligible for Medicaid acute care services and long-term services
30 and supports. (Gov. Code, Sec. 533.00251(b).)

31 Source Law

32 (b) Subject to Section 533.0025, the commission
33 shall expand the STAR + PLUS Medicaid managed care
34 program to all areas of this state to serve individuals
35 eligible for acute care services and long-term
36 services and supports under Medicaid.

37 Revisor's Note

38 Section 533.00251(b), Government Code, refers to
39 the expansion of the STAR+PLUS Medicaid managed care
40 program, "[s]ubject to Section 533.0025," Government

1 Code. The relevant provisions of Section 533.0025
2 requiring delivering Medicaid services through the
3 most cost-effective model of managed care are revised
4 in this chapter as Sections 540.0701 and 540.0753. The
5 revised law is drafted accordingly.

6 Revised Law

7 Sec. 540.0752. DELIVERY OF MEDICAID BENEFITS TO NURSING
8 FACILITY RESIDENTS. (a) In this section:

9 (1) "Clean claim" means a claim that meets the same
10 criteria the commission uses for a clean claim in reimbursing
11 nursing facility claims.

12 (2) "Nursing facility" means a convalescent or nursing
13 home or related institution licensed under Chapter 242, Health and
14 Safety Code, that provides long-term services and supports to
15 recipients.

16 (b) Subject to Section 540.0701 and notwithstanding any
17 other law, the commission shall provide Medicaid benefits through
18 the STAR+PLUS Medicaid managed care program to recipients who
19 reside in nursing facilities. In implementing this subsection, the
20 commission shall ensure that:

21 (1) a nursing facility is paid not later than the 10th
22 day after the date the facility submits a clean claim;

23 (2) services are used appropriately, consistent with
24 criteria the commission establishes;

25 (3) the incidence of potentially preventable events
26 and unnecessary institutionalizations is reduced;

27 (4) a Medicaid managed care organization providing
28 services under the program:

29 (A) provides discharge planning, transitional
30 care, and other education programs to physicians and hospitals
31 regarding all available long-term care settings;

32 (B) assists in collecting applied income from
33 recipients; and

34 (C) provides payment incentives to nursing

1 facility providers that:

2 (i) reward reductions in preventable acute
3 care costs; and

4 (ii) encourage transformative efforts in
5 the delivery of nursing facility services, including efforts to
6 promote a resident-centered care culture through facility design
7 and services provided;

8 (5) a portal is established that complies with state
9 and federal regulations, including standard coding requirements,
10 through which nursing facility providers participating in the
11 program may submit claims to any participating Medicaid managed
12 care organization;

13 (6) rules and procedures relating to certifying and
14 decertifying nursing facility beds under Medicaid are not affected;

15 (7) a Medicaid managed care organization providing
16 services under the program, to the greatest extent possible, offers
17 nursing facility providers access to:

18 (A) acute care professionals; and

19 (B) telemedicine, when feasible and in
20 accordance with state law, including rules adopted by the Texas
21 Medical Board; and

22 (8) the commission approves the staff rate enhancement
23 methodology for the staff rate enhancement paid to a nursing
24 facility that qualifies for the enhancement under the program.

25 (c) The commission shall establish credentialing and
26 minimum performance standards for nursing facility providers
27 seeking to participate in the STAR+PLUS Medicaid managed care
28 program that are consistent with adopted federal and state
29 standards. A Medicaid managed care organization may refuse to
30 contract with a nursing facility provider if the nursing facility
31 does not meet the minimum performance standards the commission
32 establishes under this section.

33 (d) In addition to the minimum performance standards the
34 commission establishes for nursing facility providers seeking to

1 participate in the STAR+PLUS Medicaid managed care program, the
2 executive commissioner shall adopt rules establishing minimum
3 performance standards applicable to nursing facility providers
4 that participate in the program. The commission is responsible for
5 monitoring provider performance in accordance with the standards
6 and requiring corrective actions, as the commission determines
7 necessary, from providers that do not meet the standards. The
8 commission shall share data regarding the requirements of this
9 subsection with STAR+PLUS Medicaid managed care organizations as
10 appropriate.

11 (e) A managed care organization may not require prior
12 authorization for a nursing facility resident in need of emergency
13 hospital services. (Gov. Code, Secs. 533.00251(a)(2), (3), (c) as
14 eff. Sept. 1, 2023, (e), (f), (h).)

15 Source Law

16 Sec. 533.00251. DELIVERY OF CERTAIN BENEFITS,
17 INCLUDING NURSING FACILITY BENEFITS, THROUGH STAR +
18 PLUS MEDICAID MANAGED CARE PROGRAM. (a) In this
19 section and Sections 533.002515 and 533.00252:

20 (2) "Clean claim" means a claim that meets
21 the same criteria for a clean claim used by the
22 Department of Aging and Disability Services for the
23 reimbursement of nursing facility claims.

24 (3) "Nursing facility" means a
25 convalescent or nursing home or related institution
26 licensed under Chapter 242, Health and Safety Code,
27 that provides long-term services and supports to
28 recipients.

29 (c) [as effective on September 1, 2023] Subject
30 to Section 533.0025 and notwithstanding any other law,
31 the commission shall provide benefits under Medicaid
32 to recipients who reside in nursing facilities through
33 the STAR + PLUS Medicaid managed care program. In
34 implementing this subsection, the commission shall
35 ensure:

36 (1) that a nursing facility is paid not
37 later than the 10th day after the date the facility
38 submits a clean claim;

39 (2) the appropriate utilization of
40 services consistent with criteria established by the
41 commission;

42 (3) a reduction in the incidence of
43 potentially preventable events and unnecessary
44 institutionalizations;

45 (4) that a managed care organization
46 providing services under the managed care program
47 provides discharge planning, transitional care, and
48 other education programs to physicians and hospitals
49 regarding all available long-term care settings;

50 (5) that a managed care organization
51 providing services under the managed care program:

1 (A) assists in collecting applied
2 income from recipients; and

3 (B) provides payment incentives to
4 nursing facility providers that reward reductions in
5 preventable acute care costs and encourage
6 transformative efforts in the delivery of nursing
7 facility services, including efforts to promote a
8 resident-centered care culture through facility
9 design and services provided;

10 (6) the establishment of a portal that is
11 in compliance with state and federal regulations,
12 including standard coding requirements, through which
13 nursing facility providers participating in the STAR +
14 PLUS Medicaid managed care program may submit claims
15 to any participating managed care organization;

16 (7) that rules and procedures relating to
17 the certification and decertification of nursing
18 facility beds under Medicaid are not affected;

19 (8) that a managed care organization
20 providing services under the managed care program, to
21 the greatest extent possible, offers nursing facility
22 providers access to:

23 (A) acute care professionals; and

24 (B) telemedicine, when feasible and
25 in accordance with state law, including rules adopted
26 by the Texas Medical Board; and

27 (9) that the commission approves the staff
28 rate enhancement methodology for the staff rate
29 enhancement paid to a nursing facility that qualifies
30 for the enhancement under the managed care program.

31 (e) The commission shall establish
32 credentialing and minimum performance standards for
33 nursing facility providers seeking to participate in
34 the STAR + PLUS Medicaid managed care program that are
35 consistent with adopted federal and state standards.
36 A managed care organization may refuse to contract
37 with a nursing facility provider if the nursing
38 facility does not meet the minimum performance
39 standards established by the commission under this
40 section.

41 (f) A managed care organization may not require
42 prior authorization for a nursing facility resident in
43 need of emergency hospital services.

44 (h) In addition to the minimum performance
45 standards the commission establishes for nursing
46 facility providers seeking to participate in the
47 STAR+PLUS Medicaid managed care program, the executive
48 commissioner shall adopt rules establishing minimum
49 performance standards applicable to nursing facility
50 providers that participate in the program. The
51 commission is responsible for monitoring provider
52 performance in accordance with the standards and
53 requiring corrective actions, as the commission
54 determines necessary, from providers that do not meet
55 the standards. The commission shall share data
56 regarding the requirements of this subsection with
57 STAR+PLUS Medicaid managed care organizations as
58 appropriate.

59 Revisor's Note

60 (1) Section 533.00251(a), Government Code,
61 provides definitions applicable to Sections
62 533.00251, 533.002515, and 533.00252, Government
63 Code. The revised law omits the reference to Section

1 533.002515, Government Code, because that section
2 expired by its own terms September 1, 2015. The
3 revised law also omits the reference to Section
4 533.00252, Government Code, because that section was
5 repealed by Chapters 837 (S.B. 200) and 946 (S.B. 277),
6 Acts of the 84th Legislature, Regular Session, 2015,
7 effective January 1, 2016.

8 (2) Section 533.00251(a)(2), Government Code,
9 refers to the Department of Aging and Disability
10 Services. The Department of Aging and Disability
11 Services was abolished September 1, 2017, in
12 accordance with Section 531.0202(b), Government Code,
13 which is executed law that expires September 1, 2023.
14 The powers and duties of that department were
15 transferred to the Health and Human Services
16 Commission. Section 531.0011, Government Code,
17 revised in this subtitle as Section _____, provides
18 that a reference to the department means the
19 commission or the appropriate division of the
20 commission. Because the department no longer exists
21 and the commission has assumed the powers and duties of
22 the department, the revised law substitutes
23 "commission" for "Department of Aging and Disability
24 Services."

25 (3) Section 533.00251(c), Government Code,
26 requires the Health and Human Services Commission to
27 provide Medicaid benefits to nursing facility
28 residents through the STAR+PLUS Medicaid managed care
29 program, "[s]ubject to Section 533.0025," Government
30 Code. The relevant provision of Section 533.0025
31 requiring delivering Medicaid services through the
32 most cost-effective model of managed care is revised
33 in this chapter as Section 540.0701. The revised law
34 is drafted accordingly.

1 Revised Law

2 Sec. 540.0753. DELIVERY OF BASIC ATTENDANT AND HABILITATION
3 SERVICES. Subject to Section _____ [[[Section 534.152]]], the
4 commission shall:

5 (1) implement the option for the delivery of basic
6 attendant and habilitation services to individuals with
7 disabilities under the STAR+PLUS Medicaid managed care program
8 that:

9 (A) is the most cost-effective; and

10 (B) maximizes federal funding for the delivery of
11 services for that program and other similar programs; and

12 (2) provide voluntary training to individuals
13 receiving services under the STAR+PLUS Medicaid managed care
14 program or their legally authorized representatives regarding how
15 to select, manage, and dismiss a personal attendant providing basic
16 attendant and habilitation services under the program. (Gov. Code,
17 Sec. 533.0025(i).)

18 Source Law

19 (i) Subject to Section 534.152, the commission
20 shall:

21 (1) implement the most cost-effective
22 option for the delivery of basic attendant and
23 habilitation services for individuals with
24 disabilities under the STAR + PLUS Medicaid managed
25 care program that maximizes federal funding for the
26 delivery of services for that program and other
27 similar programs; and

28 (2) provide voluntary training to
29 individuals receiving services under the STAR + PLUS
30 Medicaid managed care program or their legally
31 authorized representatives regarding how to select,
32 manage, and dismiss personal attendants providing
33 basic attendant and habilitation services under the
34 program.

35 Revised Law

36 Sec. 540.0754. EVALUATION OF CERTAIN PROGRAM SERVICES. The
37 external quality review organization shall periodically conduct
38 studies and surveys to assess the quality of care and satisfaction
39 with health care services provided to recipients who are:

40 (1) enrolled in the STAR+PLUS Medicaid managed care
41 program; and

1 (2) eligible to receive health care benefits under
2 both Medicaid and the Medicare program. (Gov. Code, Sec. 533.0028.)

3 Source Law

4 Sec. 533.0028. EVALUATION OF CERTAIN STAR +
5 PLUS MEDICAID MANAGED CARE PROGRAM SERVICES. The
6 external quality review organization shall
7 periodically conduct studies and surveys to assess the
8 quality of care and satisfaction with health care
9 services provided to enrollees in the STAR + PLUS
10 Medicaid managed care program who are eligible to
11 receive health care benefits under both Medicaid and
12 the Medicare program.

13 Revised Law

14 Sec. 540.0755. UTILIZATION REVIEW; ANNUAL REPORT. (a) The
15 commission's office of contract management shall establish an
16 annual utilization review process for Medicaid managed care
17 organizations participating in the STAR+PLUS Medicaid managed care
18 program. The commission shall determine the topics to be examined
19 in the review process. The review process must include a thorough
20 investigation of each Medicaid managed care organization's
21 procedures for determining whether a recipient should be enrolled
22 in the STAR+PLUS home and community-based services (HCBS) waiver
23 program, including the conduct of functional assessments for that
24 purpose and records relating to those assessments.

25 (b) The office of contract management shall use the
26 utilization review process to review each fiscal year:

27 (1) every Medicaid managed care organization
28 participating in the STAR+PLUS Medicaid managed care program; or

29 (2) only the Medicaid managed care organizations that,
30 using a risk-based assessment process, the office determines have a
31 higher likelihood of inappropriate recipient placement in the
32 STAR+PLUS home and community-based services (HCBS) waiver program.

33 (c) Not later than December 1 of each year and in
34 conjunction with the commission's office of contract management,
35 the commission shall provide a report to the standing committees of
36 the senate and house of representatives with jurisdiction over
37 Medicaid. The report must:

38 (1) summarize the results of the utilization reviews

1 conducted under this section during the preceding fiscal year;

2 (2) provide analysis of errors committed by each
3 reviewed Medicaid managed care organization; and

4 (3) extrapolate those findings and make
5 recommendations for improving the STAR+PLUS Medicaid managed care
6 program's efficiency.

7 (d) If a utilization review conducted under this section
8 results in a determination to recoup money from a Medicaid managed
9 care organization, a service provider who contracts with the
10 organization may not be held liable for providing services in good
11 faith based on the organization's authorization. (Gov. Code, Sec.
12 533.00281.)

13 Source Law

14 Sec. 533.00281. UTILIZATION REVIEW FOR STAR +
15 PLUS MEDICAID MANAGED CARE ORGANIZATIONS. (a) The
16 commission's office of contract management shall
17 establish an annual utilization review process for
18 managed care organizations participating in the STAR +
19 PLUS Medicaid managed care program. The commission
20 shall determine the topics to be examined in the review
21 process, except that the review process must include a
22 thorough investigation of each managed care
23 organization's procedures for determining whether a
24 recipient should be enrolled in the STAR + PLUS home
25 and community-based services and supports (HCBS)
26 program, including the conduct of functional
27 assessments for that purpose and records relating to
28 those assessments.

29 (b) The office of contract management shall use
30 the utilization review process to review each fiscal
31 year:

32 (1) every managed care organization
33 participating in the STAR + PLUS Medicaid managed care
34 program; or

35 (2) only the managed care organizations
36 that, using a risk-based assessment process, the
37 office determines have a higher likelihood of
38 inappropriate client placement in the STAR + PLUS home
39 and community-based services and supports (HCBS)
40 program.

41 (d) In conjunction with the commission's office
42 of contract management, the commission shall provide a
43 report to the standing committees of the senate and
44 house of representatives with jurisdiction over
45 Medicaid not later than December 1 of each year. The
46 report must:

47 (1) summarize the results of the
48 utilization reviews conducted under this section
49 during the preceding fiscal year;

50 (2) provide analysis of errors committed
51 by each reviewed managed care organization; and

52 (3) extrapolate those findings and make
53 recommendations for improving the efficiency of the
54 program.

1 (e) If a utilization review conducted under this
2 section results in a determination to recoup money
3 from a managed care organization, a service provider
4 who contracts with the managed care organization may
5 not be held liable for the good faith provision of
6 services based on an authorization from the managed
7 care organization.

8 Revisor's Note

9 (1) Sections 533.00281(a) and (b), Government
10 Code, refer to the "home and community-based services
11 and supports (HCBS) program." The revised law
12 substitutes "home and community-based services (HCBS)
13 waiver program" for the quoted language for
14 consistency in terminology used throughout this
15 chapter and because the terms are synonymous and the
16 latter is more commonly used.

17 (2) Section 533.00281(b)(2), Government Code,
18 refers to "client" placement in the STAR+PLUS home and
19 community-based services and supports (HCBS) program.
20 The revised law substitutes the term "recipient" for
21 "client" for the reason stated in Revisor's Note (2) to
22 Section 540.0054 of this chapter.

23 (3) Section 533.00281(d)(3), Government Code,
24 requires the Health and Human Services Commission to
25 prepare a report that includes recommendations on
26 improving the efficiency of "the program." It is clear
27 from the context of other portions of Section
28 533.00281 that "the program" to which Section
29 533.00281(d)(3) refers is the STAR+PLUS Medicaid
30 managed care program. Therefore, the revised law
31 substitutes "STAR+PLUS Medicaid managed care program"
32 for "program" for clarity and the convenience of the
33 reader.

34 SUBCHAPTER Q. DELIVERY OF SERVICES: STAR HEALTH PROGRAM

35 Revised Law

36 Sec. 540.0801. TRAUMA-INFORMED CARE TRAINING. (a) A STAR
37 Health program managed care contract between a Medicaid managed

1 care organization and the commission must require that
2 trauma-informed care training be offered to each contracted
3 physician or provider.

4 (b) The commission shall encourage each Medicaid managed
5 care organization providing health care services to recipients
6 under the STAR Health program to make training in post-traumatic
7 stress disorder and attention-deficit/hyperactivity disorder
8 available to a contracted physician or provider within a reasonable
9 time after the date the physician or provider begins providing
10 services under the Medicaid managed care plan the organization
11 offers. (Gov. Code, Sec. 533.0052.)

12 Source Law

13 Sec. 533.0052. STAR HEALTH PROGRAM:
14 TRAUMA-INFORMED CARE TRAINING. (a) A contract
15 between a managed care organization and the commission
16 for the organization to provide health care services
17 to recipients under the STAR Health program must
18 include a requirement that trauma-informed care
19 training be offered to each contracted physician or
20 provider.

21 (b) The commission shall encourage each managed
22 care organization providing health care services to
23 recipients under the STAR Health program to make
24 training in post-traumatic stress disorder and
25 attention-deficit/hyperactivity disorder available to
26 a contracted physician or provider within a reasonable
27 time after the date the physician or provider begins
28 providing services under the managed care plan.

29 Revised Law

30 Sec. 540.0802. MENTAL HEALTH PROVIDERS. A STAR Health
31 program managed care contract between a Medicaid managed care
32 organization and the commission must require the organization to
33 ensure that the organization maintains a network of mental and
34 behavioral health providers, including child psychiatrists and
35 other appropriate providers, in all Department of Family and
36 Protective Services regions in this state, regardless of whether
37 community-based care has been implemented in any region. (Gov.
38 Code, Sec. 533.00522.)

39 Source Law

40 Sec. 533.00522. STAR HEALTH PROGRAM: MENTAL
41 HEALTH PROVIDERS. A contract between a Medicaid
42 managed care organization and the commission for the
43 organization to provide health care services to

1 recipients under the STAR Health program must require
2 the organization to ensure the organization maintains
3 a network of mental and behavioral health providers,
4 including child psychiatrists and other appropriate
5 providers, in all Department of Family and Protective
6 Services regions in this state, regardless of whether
7 community-based care has been implemented in any
8 region.

9 Revised Law

10 Sec. 540.0803. HEALTH SCREENING REQUIREMENTS AND
11 COMPLIANCE WITH TEXAS HEALTH STEPS. (a) A Medicaid managed care
12 organization providing health care services to a recipient under
13 the STAR Health program must ensure that the recipient receives a
14 complete early and periodic screening, diagnosis, and treatment
15 checkup in accordance with the requirements specified in the
16 managed care contract between the organization and the commission.

17 (b) The commission shall encourage each Medicaid managed
18 care organization providing health care services to a recipient
19 under the STAR Health program to ensure that the organization's
20 network providers comply with the regimen of care prescribed by the
21 Texas Health Steps program under Section 32.056, Human Resources
22 Code, if applicable, including the requirement to provide a mental
23 health screening during each of the recipient's Texas Health Steps
24 medical exams a network provider conducts.

25 (c) The commission shall include a provision in a STAR
26 Health program managed care contract between a Medicaid managed
27 care organization and the commission specifying progressive
28 monetary penalties for the organization's failure to comply with
29 Subsection (a). (Gov. Code, Secs. 533.0053, 533.0054.)

30 Source Law

31 Sec. 533.0053. COMPLIANCE WITH TEXAS HEALTH
32 STEPS. The commission shall encourage each managed
33 care organization providing health care services to a
34 recipient under the STAR Health program to ensure that
35 the organization's network providers comply with the
36 regimen of care prescribed by the Texas Health Steps
37 program under Section 32.056, Human Resources Code, if
38 applicable, including the requirement to provide a
39 mental health screening during each of the recipient's
40 Texas Health Steps medical exams conducted by a
41 network provider.

42 Sec. 533.0054. HEALTH SCREENING REQUIREMENTS
43 FOR ENROLLEE UNDER STAR HEALTH PROGRAM. (a) A managed
44 care organization that contracts with the commission
45 to provide health care services to recipients under

1 the STAR Health program must ensure that enrollees
2 receive a complete early and periodic screening,
3 diagnosis, and treatment checkup in accordance with
4 the requirements specified in the contract between the
5 managed care organization and the commission.

6 (b) The commission shall include a provision in
7 a contract with a managed care organization to provide
8 health care services to recipients under the STAR
9 Health program specifying progressive monetary
10 penalties for the organization's failure to comply
11 with Subsection (a).

12 Revised Law

13 Sec. 540.0804. HEALTH CARE AND OTHER SERVICES FOR CHILDREN
14 IN SUBSTITUTE CARE. (a) The commission shall annually evaluate the
15 use of benefits offered to children in foster care under the STAR
16 Health program and provide recommendations to the Department of
17 Family and Protective Services and each single source continuum
18 contractor in this state to better coordinate the provision of
19 health care and use of those benefits for those children.

20 (b) In conducting the evaluation, the commission shall:

21 (1) collaborate with residential child-care providers
22 regarding any unmet needs of children in foster care and the
23 development of capacity for providing quality medical, behavioral
24 health, and other services for those children; and

25 (2) identify options to obtain federal matching funds
26 under Medicaid to pay for a safe home-like or community-based
27 residential setting for a child in the conservatorship of the
28 Department of Family and Protective Services:

29 (A) who is identified or diagnosed as having a
30 serious behavioral or mental health condition that requires
31 intensive treatment;

32 (B) who is identified as a victim of serious
33 abuse or serious neglect;

34 (C) for whom a traditional substitute care
35 placement contracted for or purchased by the department is not
36 available or would further denigrate the child's behavioral or
37 mental health condition; or

38 (D) for whom the department determines a safe
39 home-like or community-based residential placement could stabilize

1 the child's behavioral or mental health condition in order to
2 return the child to a traditional substitute care placement.

3 (c) The commission shall report the commission's findings
4 to the standing committees of the senate and house of
5 representatives having jurisdiction over the Department of Family
6 and Protective Services. (Gov. Code, Sec. 533.00521.)

7 Source Law

8 Sec. 533.00521. STAR HEALTH PROGRAM: HEALTH
9 CARE FOR FOSTER CHILDREN. (a) The commission shall
10 annually evaluate the use of benefits under the
11 Medicaid program in the STAR Health program offered to
12 children in foster care and provide recommendations to
13 the Department of Family and Protective Services and
14 each single source continuum contractor in this state
15 to better coordinate the provision of health care and
16 use of those benefits for children in foster care.

17 (b) In conducting the evaluation required under
18 Subsection (a), the commission shall:

19 (1) collaborate with residential
20 child-care providers regarding any unmet needs of
21 children in foster care and the development of
22 capacity for providing quality medical, behavioral
23 health, and other services for children in foster
24 care; and

25 (2) identify options to obtain federal
26 matching funds under the Medical Assistance Program to
27 pay for a safe home-like or community-based
28 residential setting for a child in the conservatorship
29 of the Department of Family and Protective Services:

30 (A) who is identified or diagnosed as
31 having a serious behavioral or mental health condition
32 that requires intensive treatment;

33 (B) who is identified as a victim of
34 serious abuse or serious neglect;

35 (C) for whom a traditional substitute
36 care placement contracted for or purchased by the
37 department is not available or would further denigrate
38 the child's behavioral or mental health condition; or

39 (D) for whom the department
40 determines a safe home-like or community-based
41 residential placement could stabilize the child's
42 behavioral or mental health condition in order to
43 return the child to a traditional substitute care
44 placement.

45 (c) The commission shall report its findings to
46 the standing committees of the senate and house of
47 representatives having jurisdiction over the
48 Department of Family and Protective Services.

49 Revisor's Note

50 Section 533.00521(b)(2), Government Code, refers
51 to "the Medical Assistance Program," which is another
52 term for Medicaid. The revised law substitutes
53 "Medicaid" for the quoted language for consistency of
54 terminology throughout this chapter.

1 Revised Law

2 Sec. 540.0805. PLACEMENT CHANGE NOTICE AND CARE
3 COORDINATION. A STAR Health program managed care contract between
4 a Medicaid managed care organization and the commission must
5 require the organization to ensure continuity of care for a child
6 whose placement has changed by:

7 (1) notifying each specialist treating the child of
8 the placement change; and

9 (2) coordinating the transition of care from the
10 child's previous treating primary care physician and specialists to
11 the child's new treating primary care physician and specialists, if
12 any. (Gov. Code, Sec. 533.0056.)

13 Source Law

14 Sec. 533.0056. STAR HEALTH PROGRAM:
15 NOTIFICATION OF PLACEMENT CHANGE. A contract between
16 a managed care organization and the commission for the
17 organization to provide health care services to
18 recipients under the STAR Health program must require
19 the organization to ensure continuity of care for a
20 child whose placement has changed by:

21 (1) notifying each specialist treating the
22 child of the placement change; and

23 (2) coordinating the transition of care
24 from the child's previous treating primary care
25 physician and treating specialists to the child's new
26 treating primary care physician and treating
27 specialists, if any.

28 Revised Law

29 Sec. 540.0806. MEDICAID BENEFITS FOR CERTAIN CHILDREN
30 FORMERLY IN FOSTER CARE. (a) This section applies only with
31 respect to a child who:

32 (1) resides in this state; and

33 (2) is eligible for assistance or services under:

34 (A) Subchapter D, Chapter 162, Family Code; or

35 (B) Subchapter K, Chapter 264, Family Code.

36 (b) Except as provided by Subsection (c), the commission
37 shall ensure that each child to whom this section applies remains or
38 is enrolled in the STAR Health program until the child is enrolled
39 in another Medicaid managed care program.

40 (c) A child to whom this section applies who received

1 Supplemental Security Income (SSI) (42 U.S.C. Section 1381 et seq.)
2 or was receiving Supplemental Security Income before becoming
3 eligible for assistance or services under Subchapter D, Chapter
4 162, Family Code, or Subchapter K, Chapter 264, Family Code, may
5 receive Medicaid benefits in accordance with the program
6 established under this subsection. To the extent allowed by federal
7 law, the commission, in consultation with the Department of Family
8 and Protective Services, shall develop and implement a program that
9 allows the adoptive parent or permanent managing conservator of a
10 child described by this subsection to elect on behalf of the child
11 to receive or continue receiving Medicaid benefits under the:

- 12 (1) STAR Health program; or
- 13 (2) STAR Kids managed care program.

14 (d) The commission shall protect the continuity of care for
15 each child to whom this section applies and ensure coordination
16 between the STAR Health program and any other Medicaid managed care
17 program for each child who is transitioning between Medicaid
18 managed care programs.

19 (e) The executive commissioner shall adopt rules necessary
20 to implement this section. (Gov. Code, Sec. 533.00531.)

21 Source Law

22 Sec. 533.00531. MEDICAID BENEFITS FOR CERTAIN
23 CHILDREN FORMERLY IN FOSTER CARE. (a) This section
24 applies only with respect to a child who:

- 25 (1) resides in this state; and
- 26 (2) is eligible for assistance or services

27 under:

- 28 (A) Subchapter D, Chapter 162, Family
29 Code; or
- 30 (B) Subchapter K, Chapter 264, Family
31 Code.

32 (b) Except as provided by Subsection (c), the
33 commission shall ensure that each child described by
34 Subsection (a) remains or is enrolled in the STAR
35 Health program unless or until the child is enrolled in
36 another Medicaid managed care program.

37 (c) If a child described by Subsection (a)
38 received Supplemental Security Income (SSI) (42 U.S.C.
39 Section 1381 et seq.) or was receiving Supplemental
40 Security Income before becoming eligible for
41 assistance or services under Subchapter D, Chapter
42 162, Family Code, or Subchapter K, Chapter 264, Family
43 Code, as applicable, the child may receive Medicaid
44 benefits in accordance with the program established
45 under this subsection. To the extent permitted by
46 federal law, the commission, in consultation with the

1 Department of Family and Protective Services, shall
2 develop and implement a program that allows the
3 adoptive parent or permanent managing conservator of a
4 child described by this subsection to elect on behalf
5 of the child to receive or, if applicable, continue
6 receiving Medicaid benefits under the:

7 (1) STAR Health program; or

8 (2) STAR Kids managed care program.

9 (d) The commission shall protect the continuity
10 of care for each child described under this section
11 and, if applicable, ensure coordination between the
12 STAR Health program and any other Medicaid managed
13 care program for each child who is transitioning
14 between Medicaid managed care programs.

15 (e) The executive commissioner shall adopt
16 rules necessary to implement this section.

17 SUBCHAPTER R. DELIVERY OF SERVICES: STAR KIDS MANAGED CARE PROGRAM

18 Revised Law

19 Sec. 540.0851. STAR KIDS MANAGED CARE PROGRAM. (a) In this
20 section, "health home" means a primary care provider practice or
21 specialty care provider practice that incorporates several
22 features, including comprehensive care coordination,
23 family-centered care, and data management, that are focused on
24 improving outcome-based quality of care and increasing patient and
25 provider satisfaction under Medicaid.

26 (b) Subject to Sections 540.0701 and 540.0753, the
27 commission shall establish a mandatory STAR Kids capitated managed
28 care program tailored to provide Medicaid benefits to children with
29 disabilities. The program must:

30 (1) provide Medicaid benefits customized to meet the
31 health care needs of program recipients through a defined system of
32 care;

33 (2) better coordinate recipient care under the
34 program;

35 (3) improve recipient:

36 (A) access to health care services; and

37 (B) health outcomes;

38 (4) achieve cost containment and cost efficiency;

39 (5) reduce:

40 (A) the administrative complexity of delivering
41 Medicaid benefits; and

42 (B) the incidence of unnecessary

1 institutionalizations and potentially preventable events by
2 ensuring the availability of appropriate services and care
3 management;

4 (6) require a health home; and

5 (7) for recipients who receive long-term services and
6 supports outside of the Medicaid managed care organization,
7 coordinate and collaborate with long-term care service providers
8 and long-term care management providers. (Gov. Code, Secs.
9 533.00253(a)(2), (b).)

10 Source Law

11 Sec. 533.00253. STAR KIDS MEDICAID MANAGED CARE
12 PROGRAM. (a) In this section:

13 (2) "Health home" means a primary care
14 provider practice, or, if appropriate, a specialty
15 care provider practice, incorporating several
16 features, including comprehensive care coordination,
17 family-centered care, and data management, that are
18 focused on improving outcome-based quality of care and
19 increasing patient and provider satisfaction under
20 Medicaid.

21 (b) Subject to Section 533.0025, the commission
22 shall, in consultation with the Children's Policy
23 Council established under Section 22.035, Human
24 Resources Code, establish a mandatory STAR Kids
25 capitated managed care program tailored to provide
26 Medicaid benefits to children with disabilities. The
27 managed care program developed under this section
28 must:

29 (1) provide Medicaid benefits that are
30 customized to meet the health care needs of recipients
31 under the program through a defined system of care;

32 (2) better coordinate care of recipients
33 under the program;

34 (3) improve the health outcomes of
35 recipients;

36 (4) improve recipients' access to health
37 care services;

38 (5) achieve cost containment and cost
39 efficiency;

40 (6) reduce the administrative complexity
41 of delivering Medicaid benefits;

42 (7) reduce the incidence of unnecessary
43 institutionalizations and potentially preventable
44 events by ensuring the availability of appropriate
45 services and care management;

46 (8) require a health home; and

47 (9) coordinate and collaborate with
48 long-term care service providers and long-term care
49 management providers, if recipients are receiving
50 long-term services and supports outside of the managed
51 care organization.

52 Revisor's Note

53 (1) Section 533.00253(b), Government Code,

1 requires the Health and Human Services Commission to
2 establish a mandatory STAR Kids capitated managed care
3 program, "[s]ubject to Section 533.0025," Government
4 Code. The relevant provisions of Section 533.0025
5 requiring delivering Medicaid services through the
6 most cost-effective model of Medicaid capitated
7 managed care are revised in this chapter as Sections
8 540.0701 and 540.0753. The revised law is drafted
9 accordingly.

10 (2) Section 533.00253(b), Government Code,
11 refers to the Children's Policy Council established
12 under former Section 22.035, Human Resources Code.
13 Former Section 22.035(n), Human Resources Code,
14 abolished the Children's Policy Council on September
15 1, 2017. Therefore, the revised law omits the
16 reference to the Children's Policy Council.

17 Revised Law

18 Sec. 540.0852. CARE MANAGEMENT AND CARE NEEDS ASSESSMENT.

19 (a) The commission may require that care management services made
20 available as provided by Section 540.0851(b)(5)(B):

21 (1) incorporate best practices as the commission
22 determines;

23 (2) integrate with a nurse advice line to ensure
24 appropriate redirection rates;

25 (3) use an identification and stratification
26 methodology that identifies recipients who have the greatest need
27 for services;

28 (4) include a care needs assessment for a recipient;

29 (5) are delivered through multidisciplinary care
30 teams located in different geographic areas of this state that use
31 in-person contact with recipients and their caregivers;

32 (6) identify immediate interventions for
33 transitioning care;

34 (7) include monitoring and reporting outcomes that, at

1 a minimum, include:

- 2 (A) recipient quality of life;
- 3 (B) recipient satisfaction; and
- 4 (C) other financial and clinical metrics the
- 5 commission determines appropriate; and
- 6 (8) use innovations in providing services.

7 (b) To improve the care needs assessment tool used for a
8 care needs assessment provided as a component of care management
9 services and to improve the initial assessment and reassessment
10 processes, the commission shall consider changes that will:

11 (1) reduce the amount of time needed to complete the
12 initial care needs assessment and a reassessment; and

13 (2) improve training and consistency in the completion
14 of the care needs assessment using the tool and in the initial
15 assessment and reassessment processes across different Medicaid
16 managed care organizations and different service coordinators
17 within the same Medicaid managed care organization.

18 (c) To the extent feasible and allowed by federal law, the
19 commission shall streamline the STAR Kids managed care program
20 annual care needs reassessment process for a child who has not had a
21 significant change in function that may affect medical necessity.
22 (Gov. Code, Secs. 533.00253(c), (c-1), (c-2).)

23 Source Law

24 (c) The commission may require that care
25 management services made available as provided by
26 Subsection (b)(7):

- 27 (1) incorporate best practices, as
- 28 determined by the commission;
- 29 (2) integrate with a nurse advice line to
- 30 ensure appropriate redirection rates;
- 31 (3) use an identification and
- 32 stratification methodology that identifies recipients
- 33 who have the greatest need for services;
- 34 (4) provide a care needs assessment for a
- 35 recipient;
- 36 (5) are delivered through
- 37 multidisciplinary care teams located in different
- 38 geographic areas of this state that use in-person
- 39 contact with recipients and their caregivers;
- 40 (6) identify immediate interventions for
- 41 transition of care;
- 42 (7) include monitoring and reporting
- 43 outcomes that, at a minimum, include:
- 44 (A) recipient quality of life;

1 (B) recipient satisfaction; and
2 (C) other financial and clinical
3 metrics determined appropriate by the commission; and
4 (8) use innovations in the provision of
5 services.

6 (c-1) To improve the care needs assessment tool
7 used for purposes of a care needs assessment provided
8 as a component of care management services and to
9 improve the initial assessment and reassessment
10 processes, the commission in consultation and
11 collaboration with the advisory committee shall
12 consider changes that will:

13 (1) reduce the amount of time needed to
14 complete the care needs assessment initially and at
15 reassessment; and

16 (2) improve training and consistency in
17 the completion of the care needs assessment using the
18 tool and in the initial assessment and reassessment
19 processes across different Medicaid managed care
20 organizations and different service coordinators
21 within the same Medicaid managed care organization.

22 (c-2) To the extent feasible and allowed by
23 federal law, the commission shall streamline the STAR
24 Kids managed care program annual care needs
25 reassessment process for a child who has not had a
26 significant change in function that may affect medical
27 necessity.

28 Revisor's Note

29 Section 533.00253(c-1), Government Code,
30 requires the Health and Human Services Commission to
31 consult and collaborate with the "advisory committee."
32 Section 533.00253(a)(1), Government Code, defines
33 "advisory committee" for purposes of Section 533.00253
34 to mean the STAR Kids Managed Care Advisory Committee.
35 The revised law omits the reference to the advisory
36 committee for the reason stated in Revisor's Note (1)
37 to Section 540.0552 of this chapter.

38 Revised Law

39 Sec. 540.0853. BENEFITS FOR CHILDREN IN MEDICALLY DEPENDENT
40 CHILDREN (MDCP) WAIVER PROGRAM. The commission shall:

41 (1) provide Medicaid benefits through the STAR Kids
42 managed care program to children receiving benefits under the
43 medically dependent children (MDCP) waiver program; and

44 (2) ensure that the STAR Kids managed care program
45 provides all of the benefits provided under the medically dependent
46 children (MDCP) waiver program to the extent necessary to implement
47 this section. (Gov. Code, Sec. 533.00253(d).)

1 criteria and are not being used to negatively impact a recipient's
2 access to care. (Gov. Code, Sec. 533.00253(n).)

3 Source Law

4 (n) The commission, at least once every two
5 years, shall conduct a utilization review on a sample
6 of cases for children enrolled in the STAR Kids managed
7 care program to ensure that all imposed clinical prior
8 authorizations are based on publicly available
9 clinical criteria and are not being used to negatively
10 impact a recipient's access to care.

11 Revisor's Note
12 (End of Subchapter)

13 Section 533.00253(a)(1), Government Code,
14 defines "advisory committee" to mean the STAR Kids
15 Managed Care Advisory Committee described by Section
16 533.00254, Government Code. The revised law omits the
17 provision for the reason stated in Revisor's Note (1)
18 to Section 540.0552 of this chapter. The omitted law
19 reads:

20 (1) "Advisory committee" means
21 the STAR Kids Managed Care Advisory
22 Committee described by Section 533.00254.

23 Revisor's Note
24 (End of Chapter)

25 Section 533.083, Government Code, requires the
26 Health and Human Services Commission, based on the
27 results of a pilot program implemented under former
28 Section 533.082, Government Code, which expired
29 September 1, 2018, to identify appropriate
30 incentive-based provider payment goals and outcome
31 measures and require Medicaid managed care
32 organizations to implement the payment goals and
33 outcome measures not later than September 1, 2018. The
34 revised law omits that section as executed. The
35 omitted law reads:

36 Sec. 533.083. ASSESSMENT AND
37 IMPLEMENTATION OF PILOT PROGRAM FINDINGS.
38 Not later than September 1, 2018, and
39 notwithstanding any other law, the
40 commission shall:

41 (1) based on the results of the
42 pilot program, identify which types of

1 incentive-based provider payment goals and
2 outcome measures are most appropriate for
3 statewide implementation and the services
4 that can be provided using those goals and
5 outcome measures; and
6 (2) require that a managed care
7 organization that has contracted with the
8 commission to provide health care services
9 to recipients implement the payment goals
10 and outcome measures identified under
11 Subdivision (1).